



Office of the
Chief Coroner

ANNUAL REPORT

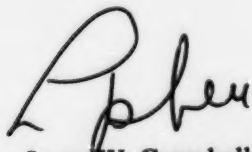
1998

February 2000

The Honourable Ujjal Dosanjh
Attorney General
British Columbia

Sir:

I have the honour to submit the 3rd Annual Report of the Office of the Chief Coroner for the year beginning January 1, 1998 and ending December 31, 1998.

A handwritten signature in black ink, appearing to read 'L. Campbell', is positioned above the printed name.

Larry W. Campbell
Chief Coroner
Province of British Columbia



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Introduction

The Office of the Chief Coroner of the Province of British Columbia is responsible by statute (*Coroners Act*) for the investigation and certification of all unnatural, sudden and unexpected/unexplained or unattended deaths.

Historic Development

The Coroners system is the oldest legal, investigative and judicial system in British Common Law. Its origin antedates Magna Carta. Although its actual beginnings are somewhat obscure, most authorities relate it back to the English Articles of Eyre in 1194. The Coroner was known as a "Keeper of the pleas of the Crown", the term 'Coroner' evolving from 'Crown'.

The former utility of the Coroner as a protector of Crown revenue, or as an agency for bringing suspects to trial, is no longer a consideration. However, what does remain constant in the face of this evolution is the continuing concern with the fact of death and the unchanged interest of the public in the protection of its members. The death of a member of society is a public fact. The circumstances that surrounded that death, and whether it could have been avoided, are matters of interest to all members of the community. In this sense, the Coroner exists to provide a truly public service, both individually and collectively.

Each province and territory in Canada presently operates its own sudden death inquiry system. In British Columbia, prior to 1972, Coroners were judicially independent, common law officers, who executed their duties as they saw fit. Service delivery was variegated and the direct involvement

of Coroners in their fieldwork was minimal. In 1972, the government examined the court system. This review included the Coroner's Courts at Vancouver and New Westminster which had been operated by those respective municipalities. By 1975, the provincial government had taken over the operations of all the courts, including facilities and staffing.

In its continued desire to provide quality court services in the province, the government of the day studied the existing Coroner systems in other provinces and some states in the United States. The Ontario legislation was copied virtually verbatim, except for the requirement that Coroners be medical practitioners. The legislation was proclaimed in 1979 and the first Chief Coroner was appointed. Objectives in 1982-83 included improving the quality of Coroners investigations and forensic medical investigations; improving the quality of judicial decision-making in Coroners inquests and inquiries; and improving record keeping and access to recommendations and their follow-up. The Service then developed decentralized forensic pathology, toxicology and in-house training capabilities.

Emerging from this, three basic principles are manifest in the BC Coroners Service:

1. It is a fact-finding, not a fault-finding agency.
2. It is an independent service for the people of the community.
3. It serves firstly the deceased and relatives and friends of the deceased; secondly, society as a whole; and thirdly, government agencies and other organizations.

Two major program areas, investigative and judicial, form the basis for the raison d'être of the Coroners Service — the prevention of death.

The British Columbia Coroners Service

Organizational Structure

In British Columbia the Coroners Service, for organization, budget and administrative purposes, falls within the Ministry of Attorney General's vote. The Chief Coroner, whose office is located in Burnaby, supervises the Coroners Service. There are eight regional offices, each headed by a Regional Coroner who is directly responsible for all Coroners activities within his/her region. Regional offices are located in Victoria, Nanaimo, Vancouver, New Westminster, Abbotsford, Kamloops, Kelowna and Prince George.

In 1998, the Coroners Service had 38 full-time employees, of whom 21 functioned as full-time Coroners. There were 120 appointed fee-for-service Coroners who provided much needed services to local, and sometimes remote, communities.

During the course of an investigation, establishing the means of death is more than simply determining the medical cause of death. The question of why the individual died mandates a careful examination of the circumstances leading up to the death. To assist the Coroner in carrying out this function, professionals, or a team of professionals, may be assigned to a case. The following special areas of investigation are primarily provided on a fee-for-service basis:

Pathology

The authority to order an autopsy is an absolute power that the Coroner must possess if the Coroners Service is to be effective. In deciding

whether or not an autopsy is required, the Coroner must deem it necessary in order to determine the precise cause and manner of death. The autopsy must be considered to be in the public interest. In general, if a reasonable and probable cause of death can be deduced on the basis of the decedent's medical history, the circumstances surrounding death and a careful examination of the body, an autopsy may not be necessary for the Coroners mandate.

The forensic autopsy is a very specialized autopsy, performed for special reasons. There is a great difference between a hospital autopsy and a forensic autopsy. Hospital autopsies are directed towards substantiating the accuracy of a diagnosis and therapy instituted during the course of an illness, as well as determining the immediate cause of death. The Coroner authorizes a forensic or medico-legal autopsy to determine the cause of death where it cannot otherwise be determined; to collect evidence from the body, to document findings useful in clarifying time and circumstances of death; and finally, to obtain evidence aiding in the identification of the body.

The Coroners Service investigates approximately 9,500 deaths per year in the province. Autopsies are ordered by the Coroner in approximately 30% of all cases reported. In British Columbia the Coroners Service retains the services of pathologists who conduct medico-legal autopsies on a fee-for-service basis.

Toxicology

In conjunction with the medico-legal autopsy, Coroners authorize toxicology testing where it is required to establish or confirm the cause and manner of death. For the most part, toxicology testing is provided on a fee-for-service basis at the

Provincial Toxicology Centre, an accredited laboratory, located at Riverview Hospital in Port Coquitlam, B.C. In cases also under criminal investigation, toxicology testing is conducted by the RCMP Crime Laboratory. To a lesser degree, some toxicology testing is performed at regional hospitals.

Forensic Identification Unit

This unit provides province-wide support to investigative coroners who require assistance with recovery of human remains that have been extensively compromised, difficult identifications, and the investigation of historic unidentified cases. The Forensic Unit co-ordinates forensic services in the areas of: archaeology, botany, entomology, anthropology, osteology, odontology, radiology, and DNA.

Medical Investigations

When Coroners' cases involve complex medical facts, registered nurses and occasionally medical doctors are assigned to review medical charts and interview persons who cared for the deceased. The information collected establishes the factual chronology of events to assess concerns, to develop recommendations and to prevent future deaths. The medical investigator prepares a specialized summary investigative report for the Coroner.

Behavioural Investigations

The Chief Coroner also retains behaviour analysts with backgrounds in psychology and social work to assist Coroners in cases where it is difficult to determine whether or not the incident was a suicide, accident or homicide. These analysts can also help in answering the question of WHY in known suicide cases. Behaviourists focus on the questions of WHY and PREVENTABILITY.

Coroners Act & Notification Requirement

Section 9 of the *Coroners Act* sets out the requirement for reporting a death to the Coroner. This section of the *Act* requires that a person shall immediately notify a Coroner or peace officer of the facts and circumstances relating to a death where he/she has reason to believe that a person has died under circumstances where an investigation may be required. The *Act* specifically requires the reporting of violent, unexplained or sudden/unexpected deaths; deaths in custody; and deaths of persons to whom the *Mental Health Act* applies.

The Coroners Service is responsible for the investigation of all reported deaths in order to determine for each case, the identity of the deceased and the facts as to how, when, where and by what means the deceased came to his/her death. The system, therefore, is a vital part of law enforcement in initially determining whether such deaths are due to natural causes, accident, suicide or homicide.

The purpose of the Coroner's investigation has changed over the years. Previously, major emphasis was directed towards the investigation of the actual medical cause of death to the exclusion of practically all other aspects. Now, the medical cause of death is only one of many factors to be considered. The non-medical factors causing death are often equally important.

When a death is reported to a Coroner, an investigation is commenced immediately with the focus on determining, as provided in Section 27(1) of the *Act*, who the deceased was and how, when,

where and by what means death occurred. In conducting such investigations, the Coroner has extensive authority to collect information, conduct interviews and seize documents or other materials. In this regard, the Coroner may rely on information received from other agencies such as the Workers' Compensation Board in industrial related deaths or from the local police regarding deaths that may be crime-related. The ultimate objective is to undertake a thorough investigation so that the requirements of Section 27 are fully achieved. As some reported deaths involve elements of criminality, the investigation sometimes involves a combination of Coroner and police responsibility and requires a close liaison between the two agencies.

Inquiry vs Inquest

Coroners' investigations may be concluded by one of two procedures. The most common approach is for the Coroner to conduct an Inquiry and prepare a report for the Chief Coroner as provided by Section 20 of the *Coroners Act*. A Coroner's Inquiry is a quasi-judicial process conducted without a jury by the Coroner. The Coroner interviews witnesses as required and reviews all investigative documents gathered from other agencies and then determines the facts. The Coroner's findings and recommendations are reported in a Judgment of Inquiry. This report will outline the factual circumstances relating to the death and determine the medical cause of death, as well as classifying the death as natural, accidental, suicide, homicide or undetermined. Recommendations, where called for, are made to specific individuals and/or agencies, suggesting changes or improvements be made so that similar deaths or injuries can be prevented.

The remainder of investigations is concluded by an inquest, a quasi-judicial hearing held in an open forum, with witnesses being subpoenaed to testify under oath before a jury of five persons. An inquest is not a forum to resolve civil disputes, or to conduct prosecutions. An inquest is not a trial and a Coroner is not a judge. The proceedings are investigational as opposed to accusatory or adversarial. Thus, there is no "accused" or "defendant" and no "parties" or "lis". There are several reasons to hold an inquest. Section 10 of the *Act* makes it mandatory to hold inquests into deaths of persons while in police custody. Section 18 provides for the calling of an inquest when the Coroner determines it to be "necessary". Section 21 provides that a Coroner conducting an inquiry may, for reasons specified in Section 21, change the inquiry to an inquest and summon a jury for that purpose. Over time, these latter two sections have been generally interpreted to call for an inquest because of:

1. serious concerns of the public or next of kin;
2. the refusal of a witness to voluntarily provide evidence to a Coroner conducting an inquiry; and/or
3. agencies, institutions and interest groups legitimately pointing out concerns worthy of public focus.

The Attorney General may also, under special circumstances, direct an inquest be held as provided in Section 23 of the *Coroners Act*.

Inquest proceedings begin with the Coroner explaining the mandate to the jury and their responsibilities under the *Coroners Act*. The Coroner reviews applicable sections of the *Coroners Act* for the information of the jury and gives a short summation of facts relating to the death. Witnesses are then called and examined by

Coroner's counsel, the Coroner, members of the jury and persons granted standing. Persons are given standing if their interests may be affected by evidence called. They, or their representative, may participate fully in the inquest by asking questions and calling evidence. Once all the evidence has been given, the Coroner adjourns the court and prepares a summation or overview of the evidence presented. The hearing is then reconvened and the summation given to the jury. The jury then prepares its verdict which may be unanimous or by majority. The verdict and findings must not make any finding of legal responsibility or express any conclusion of law.

The *Coroners Act* provides no power to order change. The Coroner, however, submits the jury's recommendations to the Chief Coroner for dissemination to appropriate persons, agencies and ministries of governments. The jury recommendations must be lawful and are expected to be relevant and reasonable.

Coroner & Jury Recommendations

The mandate of the Coroner is to determine the relevant facts and, where appropriate or feasible, to make recommendations so that a similar death is less likely to occur in the future. Coroner's recommendations flow directly from the circumstances of individual deaths.

Although recommendations from either a jury or Coroner are generally viewed as compelling, the Coroners Service has no statutory authority to order change or to ensure that the recommendations will be carried out. Despite the lack of legal enforcement powers, the Coroners Service is

successful in having most of its recommendations considered and acted upon.

On average, approximately 2500 recommendations are forwarded to various agencies in a year. The majority of responses received are either positive, under active consideration, or acknowledged as already being in place. As a direct result of Coroner and jury recommendations, policies and practices have been altered, more monitoring has occurred, and greater care and attention paid to altering conditions, which might cause injury or death in the future.

Statistical Summary of Deaths

Statistical Reporting

The Coroner's Case Management System, CCMS, is an on-line Oracle database that maintains information on all reported deaths in British Columbia.

CCMS was developed in 1992 to assist in tracking and summarizing case information and is utilized for two main purposes: to facilitate enquiries and for statistical reporting of deaths. This statistical reporting is accomplished by using a coding system based on definitions adopted from the World Health Organization's, *International Classification of Diseases*.

Cause of Death Codes

The primary definitions consist of CAUSE OF DEATH and MEANS OF DEATH:

"CAUSES OF DEATH are all those diseases, morbid conditions or injuries which either resulted in, or contributed to, death and the circumstances of the accident or violence which produced the injuries."

The "UNDERLYING CAUSE OF DEATH OR MEANS OF DEATH is (a) the disease or injury which initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury."

For the purpose of death prevention, it is vital to capture the precipitating event or Means of Death to provide researchers with meaningful data.

Vital Statistics

The *Vital Statistics Act* requires that a Coroner or physician provide a Medical Certificate of Death for each death in British Columbia. The certificate is filed with a District Registrar of Births, Deaths & Marriages within 48 hours of the death. The funeral director, or person acting as such, is required to complete the Registration of Death, collect the Medical Certificate of Death and file both with the District Registrar. If the cause of death cannot be determined within the time required, the Coroner provides a provisional certificate that is later updated with the appropriate cause of death information.

Besides requiring this information for official records, the Division of Vital Statistics, Research Branch utilizes mortality data for various aspects of health planning and education. They produce and disseminate relevant measures of health status, thus providing valuable information to health care researchers, planners and providers alike.

Classifications of Death

As of October 1993, all deaths reported to and investigated by the Coroners Service have been classified for statistical purposes into the following five categories:

A **Natural** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.

An **Accident** is a death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.

A **Suicide** is a death resulting from self inflicted injury, with intent to cause death.

A **Homicide** is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.

An **Undetermined** death is defined as one which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

The Coroners Service maintains a separate category, referred to as a **Non Coroners Case**. A non-Coroners case is a natural death where none of the criteria of Section 9 of the *Coroners Act* are met. Following a brief investigation, the Coroner may conclude the case as such if he or she is satisfied that the death was natural and an attending medical practitioner is prepared to certify the cause of death.

Injury Prevention

The Coroner's files are being used by a variety of agencies to collect valuable research data. The Coroners Service facilitates this research to ensure deaths in certain categories are collectively reviewed so that provincial and/or federal accident/suicide and injury prevention strategies can be adopted. These agencies are vetted by the Coroners Service and sign a research agreement, which ensures security and confidentiality in collecting only the necessary demographic information.

The following agencies make use of Coroners' files, on an annual basis for their injury/death prevention strategies:

Red Cross

The Canadian Red Cross and the Royal Life Saving Society Canada have combined efforts to work with communities across BC and the Yukon to reduce the number of water-related fatalities and injuries. These agencies produce a joint provincial summary of drownings in BC and the Yukon. Coroners' Service files provide the necessary data to allow these agencies to fulfil their role in educating the public, and work with the injury prevention community in reducing injuries and death due to drowning.

Traffic Injury Research Foundation

The Traffic Injury Research Foundation of Canada (TIRF) has used Coroners' files to compile data on alcohol-use related to motor vehicle fatalities since 1974. A fatality database is maintained for all provinces across Canada. This database provides a comprehensive source of objective data on alcohol use among persons fatally injured in motor vehicle accidents; it is a means of monitoring changes/trends and is a valuable tool for research on alcohol-impaired driving.

The University of British Columbia - Mental Health Evaluation & Community Consultation Unit (MHECCU)

The MHECCU at the University of British Columbia and the Coroners Service have a unique partnership, which supports the development and maintenance of a provincial database on suicide occurrences. The MHECCU program provides provincial leadership, information/research findings and consultation and support to community partners throughout the province. The goal is to facilitate the development of a comprehensive approach to youth suicide prevention, reflecting the needs and priorities of local communities throughout B.C.

Coroners complete a summary form on every suicide in B.C. and this information is consolidated and maintained in a provincial database by the MHECCU program. Their goal is to produce periodic reports summarizing the psychosocial information for all completed suicides in BC. This

report is distributed to key individuals and agencies working in the area of suicide prevention in B.C. Up-to-date, reliable information about the nature and circumstances surrounding completed suicides is essential to good prevention planning and programs.

Underwater Council of British Columbia

The Underwater Council of British Columbia states that "through education and communication, it is dedicated to furthering safe diving practices". As such, the Council undertakes to review all Coroners' diving files on a yearly basis to produce a Recreational Diving Fatalities report which summarizes circumstances and recommendations on diving deaths. This report is an invaluable reference for scuba instructors, educators and concerned scuba enthusiasts.

Canadian Agricultural Injury Surveillance Program

The purpose of the Canadian Agricultural Injury Surveillance Program is to collect and interpret information on agricultural injury across Canada. They review all cases identified by the Coroner as 'farm' related and abstract data from the files. The results are combined with data from other provinces to form the National Registry of Farm Fatalities. A final report is produced which aims to summarize risks, trends, and other patterns among farm fatalities. This provides farm safety specialists with an objective basis from which to develop and target farm safety programs across Canada.

CASELOAD STATISTICS (1998)

Total Cases

Manner of Death	Total Cases
Natural	3822
Accident	1491
Homicide	91
Suicide	511
Undetermined	115
Non Coroners	3604
Total	9634

Regional Distribution

	Natural	Accident	Homicide	Suicide	Undetermined	NCC
Nanaimo	317	133	7	56	16	270
Victoria	356	132	12	61	4	504
New Westminster	839	208	19	96	17	757
Abbotsford	430	137	12	45	25	398
Vancouver	842	378	19	113	27	674
Kamloops	365	225	8	59	11	304
Kelowna	436	111	5	40	4	467
Prince George	237	167	9	41	11	230
Total	3822	1491	91	511	115	3604

Regional Caseload Review (1994-1998)

	1998	1997	1996	1995	1994
Nanaimo	799	758	881	851	795
Victoria	1069	1097	1132	1122	1187
New Westminster	1936	1933	2378	2009	2182
Abbotsford	1047	1081	776	726	721
Vancouver	2053	1941	1962	1914	1989
Kamloops	972	1062	1063	1051	1113
Kelowna	1063	1082	1014	987	967
Prince George	695	626	694	693	689
Total	9634	9580	9900	9353	9643

* The B.C. Coroners Service operates in a "live" database environment and, as such, data is continuously updated.

ACCIDENTAL DEATHS (1998)

Recreational

Swimming	11
Sailboating/Sailboarding	2
Power Boating	7
Non Power Boating	-
Kayak	1
Inner tube	1
Dinghy	1
Rowboat	2
Canoe	7
Rafting	2
Other	1
Scuba Diving	2
Snorkelling	-
Windsurfing	-
Diving	2
Hunting	2
Fishing	10
Snowskiing	10
Heli-skiing	-
Snowmobiling	6
Snowboarding	3
Tobogganing	-
Skateboarding	-
Hiking/Climbing	9
ATV/Off-road Motorcycling	9
Skydiving/Parachuting	-
Ultra-light Aircraft	2
Team Sports	-
Other	-

Occupational

Farm/Worksite	-
Mine, Quarry, Oil/Gas	2
Construction:	
Residential	1
Commercial	4
Excavating/Paving/Grading	-
Electrical/Powerlines	-
Industrial Sites	5
Material Handling	-
Forestry/Logging Sites	9
Railway Sites	-
Fishing/Hunting/Trapping	2
Commercial Scuba Diving	1
Other	14

Other Accidents

Motor Vehicle	433
Alcohol/Drug Poisoning	489
Fall	205
Other	56
Drowning (does not contain drownings included in recreational category i.e., swimming)	24
Airway Obstruction	26
Fire	30
Air Crash	9
Exposure	14
Carbon Monoxide Poisoning	10
Explosion	-
Farm	7
Firearms	1
Railway	6
Non-Traffic (on driveway etc.)	6
Pedal Cyclist	1
Unclassified	43*

* **Unclassified** represents cases in which the cause of death has not yet been finalized.

MOTOR VEHICLE ACCIDENTS

By Victim Type

Driver	191
Passenger	117
Motorcyclist	26
Pedestrian	66
MVA/Pedal Cyclist	10
MVA/Train Collision	-
Other	5
Unclassified	18
Total	433

Regional Distribution

	Driver	Pass- enger	Motor- cyclist	Pedestrian	Pedal Cyclist	MVA/ Rail	Other	Unclass- ified	Total
Abbotsford	22	13	1	6	-	-	-	2	44
Kamloops	49	33	2	3	2	-	-	5	94
Kelowna	19	10	4	4	-	-	2	-	39
Nanaimo	15	9	3	1	2	-	1	-	31
New Westminster	21	15	6	17	2	-	-	-	61
Prince George	39	22	3	9	1	-	1	10	85
Vancouver	18	8	5	24	2	-	1	1	59
Victoria	8	7	2	2	1	-	-	-	20
Total	191	117	26	66	10	-	5	18	433

CHILD DEATH REVIEW (Ages 0-18 yrs)

Total Cases Reported, 1994-1998

	1998	1997	1996	1995	1994
Natural	48	68	75	88	101
Accident	89	110	112	124	130
Homicide	4	19	14	15	25
Suicide	18	29	15	26	20
Undetermined	17	10	11	11	8
Non Coroners	45	50	50	58	60
Total	221	286	277	322	344

Age Distribution

	1998	1997	1996	1995	1994
<1 yr	68	89	99	125	127
1 - 4	28	31	28	22	54
5 - 9	21	31	26	21	25
10-14	27	34	34	39	36
15-18	77	101	90	115	102
Total	221	286	277	322	344

Accidental Child Deaths by Means of Death

	1998	1997	1996	1995	1994
Motor Vehicle	47	62	62	75	69
Drowning	11	9	16	11	18
Airway Obstruction	2	5	5	12	8
Falls	3	5	4	6	3
Alcohol/Drug Poisoning	3	4	7	2	14
Fire	4	2	2	2	5
Air	-	-	1	2	2
Other	8	21	15	14	11
Outstanding Cases	11	2	-	-	-
Total	89	110	112	124	130

* The B.C. Coroners Service operates in a "live" database environment, and as such, data is continuously updated.

SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death, 10-Year Review (1989-1998)

Year	No. of Deaths
1989	78
1990	67
1991	78
1992	64
1993	50
1994	40
1995	50
1996	25
1997	26
1998	13

Sudden Infant Death (Regional Distribution)

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Abbotsford	2	1	5	8	-	3	5	1	1	1
Kamloops	3	7	8	2	5	4	6	2	2	2
Kelowna	3	1	4	5	2	1	3	-	1	2
Nanaimo	12	10	7	11	9	8	8	5	4	1
New Westminster	24	15	23	11	12	13	9	8	7	2
Prince George	13	17	14	6	11	3	9	3	4	2
Vancouver	16	9	11	15	5	4	4	2	3	1
Victoria	5	7	6	6	6	4	6	4	4	2
Total	78	67	78	64	50	40	50	25	26	13

SUICIDES

B.C. Suicide Rates per 100,000 Population

Year	Number of Suicides	Rate per 100,000
1986	483	6.0
1987	459	15.0
1988	456	14.6
1989	489	15.3
1990	426	12.9
1991	488	14.4
1992	514	14.8
1993	492	13.8
1994	513	14.0
1995	534	14.2
1996	557	14.3
1997	582	14.7
1998	511	12.7

B.C. Five Year Suicide Review

	1998	1997	1996	1995	1994
< 13 yrs	1	3	1	0	0
13 - 19	22	37	18	35	29
20 - 29	74	94	91	109	97
30 - 39	110	129	129	124	139
40 - 49	129	128	125	86	101
50 - 59	77	80	71	67	57
60 - 69	42	49	57	50	47
70 - 79	31	39	36	41	29
Over 80	25	23	29	22	13
Total	511	582	557	534	*513
 Males	 396	 458	 429	 425	 396
Females	115	124	128	109	117
 Abbotsford Region	 45	 49	 53	 26	 40
Kamloops Region	59	67	59	63	47
Kelowna Region	40	50	44	49	57
Nanaimo Region	56	59	69	54	52
New Westminster	96	110	107	124	108
Prince George Region	41	51	39	41	43
Vancouver Region	113	133	129	117	106
Victoria Region	61	63	57	60	60

* One case for 1994 where no age available.

B.C. Five-Year Suicide Review Cont.

Suicides by Method of Death

	1998	1997	1996	1995	1994
Airway Obstruction	152	175	165	148	147
Carbon Monoxide	71	58	76	65	48
Drowning	19	25	28	20	21
Falls	22	43	39	40	32
Firearms	97	133	110	138	133
Incised Injuries	8	16	11	9	13
Other	12	17	18	8	17
Poisoning	110	103	110	106	102
Unclassified	20	12	-	-	-
Total	511	582	557	534	513

Suicides in B.C. by Township

	1998	1997	1996	1995	1994
FRASER VALLEY REGION	45	49	53	26	40
ABBOTSFORD	7	12	14	9	5
AGASSIZ	-	-	3	2	2
ALDERGROVE	-	1	-	-	-
BOSTON BAR	-	-	2	2	1
CHEHALIS	-	-	-	-	2
CHILLIWACK	10	7	14	7	6
CLEARBROOK	-	-	-	-	2
CULTUS LAKE	-	-	-	-	1
HARRISON HOT SPRINGS	1	-	-	-	-
HARRISON MILLS	-	-	1	-	1
HOPE	1	4	6	2	2
LANGLEY	13	8	-	-	-
MAPLE RIDGE	6	10	-	-	-
MATSQUI	-	-	-	-	1
MISSION	4	7	11	2	10
NORTH	-	-	-	1	-
PITT MEADOWS	3	-	-	-	-
SARDIS	-	-	2	1	6
YARROW	-	-	-	-	1
NEW WESTMINSTER REGION	96	110	107	124	108
ALDERGROVE	-	-	1	2	1
BURNABY	17	22	23	24	14
CLOVERDALE	-	-	1	-	-
COQUITLAM	16	7	9	8	7
DELTA	7	8	3	11	12
LADNER	-	-	-	1	-
LANGLEY	-	-	4	9	7
MAPLE RIDGE	-	-	5	4	3
NEW WESTMINSTER	8	14	10	8	14
PITT MEADOWS	-	-	2	-	1
PORT COQUITLAM	6	7	4	8	5
PORT MOODY	1	-	1	2	1
RICHMOND	9	20	15	17	12
SURREY	31	31	27	28	29
TSAWWASSEN	-	-	1	-	-
WHITE ROCK	1	1	1	2	2
VANCOUVER REGION	113	133	129	117	105
BOWEN ISLAND	1	-	-	-	-
BRACKENDALE	-	-	-	1	-
BRITANNIA BEACH	-	-	-	1	-
FURRY CREEK	-	1	-	-	-
GARDEN BAY	-	1	-	1	-
GIBSONS	1	2	-	3	4
HALFMOON BAY	-	1	-	-	-
LIONS BAY	-	-	-	1	-



Suicides in B.C. by Township

	1998	1997	1996	1995	1994
FRASER VALLEY REGION	45	49	53	26	40
ABBOTSFORD	7	12	14	9	5
AGASSIZ	-	-	3	2	2
ALDERGROVE	-	1	-	-	-
BOSTON BAR	-	-	2	2	1
CHEHALIS	-	-	-	-	2
CHILLIWACK	10	7	14	7	6
CLEARBROOK	-	-	-	-	2
CULTUS LAKE	-	-	-	-	1
HARRISON HOT SPRINGS	1	-	-	-	-
HARRISON MILLS	-	-	1	-	1
HOPE	1	4	6	2	2
LANGLEY	13	8	-	-	-
MAPLE RIDGE	6	10	-	-	-
MATSQUI	-	-	-	-	1
MISSION	4	7	11	2	10
NORTH	-	-	-	1	-
PITT MEADOWS	3	-	-	-	-
SARDIS	-	-	2	1	6
YARROW	-	-	-	-	1
NEW WESTMINSTER REGION	96	110	107	124	108
ALDERGROVE	-	-	1	2	1
BURNABY	17	22	23	24	14
CLOVERDALE	-	-	1	-	-
COQUITLAM	16	7	9	8	7
DELTA	7	8	3	11	12
LADNER	-	-	-	1	-
LANGLEY	-	-	4	9	7
MAPLE RIDGE	-	-	5	4	3
NEW WESTMINSTER	8	14	10	8	14
PITT MEADOWS	-	-	2	-	1
PORT COQUITLAM	6	7	4	8	5
PORT MOODY	1	-	1	2	1
RICHMOND	9	20	15	17	12
SURREY	31	31	27	28	29
TSAWWASSEN	-	-	1	-	-
WHITE ROCK	1	1	1	2	2
VANCOUVER REGION	113	133	129	117	105
BOWEN ISLAND	1	-	-	-	-
BRACKENDALE	-	-	-	1	-
BRITANNIA BEACH	-	-	-	1	-
FURRY CREEK	-	1	-	-	-
GARDEN BAY	-	1	-	1	-
GIBSONS	1	2	-	3	4
HALFMOON BAY	-	1	-	-	-
LIONS BAY	-	-	-	1	-

VANCOUVER REGION CONT.	1998	1997	1996	1995	1994
MT. CURRIE	-	-	-	-	1
NORTH VANCOUVER	10	13	12	11	10
PEMBERTON	2	-	1	-	1
PENDER HARBOUR	-	1	-	-	1
ROBERTS CREEK	-	-	-	1	-
SECHLT	4	2	1	1	1
SKOOKUM CHUCK	-	-	1	-	-
SQUAMISH	4	2	5	3	5
VANCOUVER	89	105	107	87	76
WEST VANCOUVER	2	5	2	6	5
WHISTLER	-	-	-	1	1
KAMLOOPS REGION	59	67	59	63	47
100 MILE HOUSE	4	-	1	-	-
ASHCROFT	-	-	-	-	1
BALFOUR	-	1	-	-	-
BARRIERE	-	-	-	3	3
BEAVER FALLS	-	-	1	-	-
CACHE CREEK	-	1	-	1	-
CANIM LAKE	-	1	1	1	-
CASTLEGAR	-	3	2	1	-
CHASE	1	5	1	1	-
CLEARWATER	-	-	-	-	1
CRANBROOK	8	2	5	2	4
CRESCENT VALLEY	-	1	-	-	-
CRESTON	-	3	-	-	1
DEKA LAKE	-	-	-	1	-
EDGEWOOD	-	1	1	-	-
ELKFORD	-	-	1	-	-
ERICKSON	4	-	-	-	-
FAUQUIER	-	-	-	-	1
FERNIE	2	1	-	-	-
FOREST GROVE	-	1	1	-	-
FORT STEELE	-	-	1	1	-
FRUITVALE	-	-	1	1	-
GALENA BAY	-	-	1	-	-
GENELLE	-	-	1	-	1
GOLDEN	-	2	1	-	2
GRAND FORKS	2	2	2	-	-
GREENWOOD	-	-	1	-	-
HARROGATE	-	-	1	-	-
HARROP	-	-	-	1	-
HOSMER	-	1	-	-	-
INVERMERE	-	-	1	3	-
KAMLOOPS	17	21	15	15	11
KASLO	-	1	-	1	-
KIMBERLEY	-	2	-	-	1
LAC LA HACHE	-	1	1	-	-
LAC LE JEUNE	1	-	-	-	-
LILLOOET	-	-	3	1	-
LISTER	-	-	1	-	-
LONE BUTTE	-	-	1	-	-

KAMLOOPS REGION CONT.	1998	1997	1996	1995	1994
LOWER NICOLA	1	-	-	-	-
LYTTON	-	-	-	2	2
MAGNA BAY	-	-	-	-	1
MERRITT	3	3	-	4	2
MIDWAY	-	1	-	-	-
MONTE LAKE	-	-	1	-	-
NAKUSP	-	1	-	-	1
NELSON	-	3	2	1	-
NEW DENVER	1	-	-	1	-
POTPOUR	1	-	-	-	-
PRITCHARD	1	-	-	-	-
QUEENS BAY	-	-	-	-	1
RADIUM HOT SPRINGS	-	1	-	-	1
RASPBERRY	-	-	-	1	-
REVELSTOKE	1	1	-	4	2
ROCK CREEK	-	1	-	-	-
ROSSLAND	-	-	2	-	1
SALMO	1	-	-	2	2
SALMON ARM	2	2	4	7	1
SICAMOUS	1	-	1	2	-
SILVERTON	-	-	1	-	-
SLOCAN	-	-	-	1	-
SORRENTO	-	1	-	-	1
SPARWOOD	-	-	-	-	2
SPENCES BRIDGE	-	-	-	1	-
SPILLIMACHEEN	-	-	-	-	1
TAPPEN	-	-	2	2	-
TATA CREEK	-	1	-	-	-
TRAIL	5	1	-	1	2
VINSULA	1	-	-	-	-
WARFIELD	1	-	-	-	-
WINLAW	-	-	-	1	1
WYCLIFF	-	-	1	-	-
YMIR	-	1	-	-	-
KELOWNA REGION	40	50	44	49	57
ALLISON LAKE	-	-	1	-	-
ARMSTRONG	1	-	1	1	1
BRIDESVILLE	-	-	-	-	1
COALMONT	-	-	-	1	-
ENDERBY	2	2	2	-	1
FALKLAND	-	-	-	1	-
FAULDER	-	1	-	-	-
HEDLEY	-	-	2	-	-
IDEAL LAKE	-	-	-	-	1
KALEDEN	-	-	-	1	-
KELOWNA	13	22	12	18	15
KEREMEOS	1	1	1	1	3
LAVINGTON	-	-	1	-	-
LUMBY	1	1	1	1	-
NARAMATA	-	-	-	2	1
OKANAGAN FALLS	-	-	-	-	1

VANCOUVER REGION CONT.	1998	1997	1996	1995	1994
MT. CURRIE	-	-	-	-	1
NORTH VANCOUVER	10	13	12	11	10
PEMBERTON	2	-	1	-	1
PENDER HARBOUR	-	1	-	-	1
ROBERTS CREEK	-	-	-	1	-
SECHLT	4	2	1	1	1
SKOOKUM CHUCK	-	-	1	-	-
SQUAMISH	4	2	5	3	5
VANCOUVER	89	105	107	87	76
WEST VANCOUVER	2	5	2	6	5
WHISTLER	-	-	-	1	1
KANLOOPS REGION	59	67	59	63	47
100 MILE HOUSE	4	-	1	-	-
ASHCROFT	-	-	-	-	1
BALFOUR	-	1	-	-	-
BARRIERE	-	-	-	3	3
BEAVER FALLS	-	-	1	-	-
CACHE CREEK	-	1	-	1	-
CANIM LAKE	-	1	1	1	-
CASTLEGAR	-	3	2	1	-
CHASE	1	5	1	1	-
CLEARWATER	-	-	-	-	1
CRANBROOK	8	2	5	2	4
CRESCENT VALLEY	-	1	-	-	-
CRESTON	-	3	-	-	1
DEKA LAKE	-	-	-	1	-
EDGEWOOD	-	1	1	-	-
ELKFORD	-	-	1	-	-
ERICKSON	4	-	-	-	-
FAUQUIER	-	-	-	-	1
FERNIE	2	1	-	-	-
FOREST GROVE	-	1	1	-	-
FORT STEELE	-	-	1	1	-
FRUITVALE	-	-	1	1	-
GALENA BAY	-	-	1	-	-
GENELLE	-	-	1	-	1
GOLDEN	-	2	1	-	2
GRAND FORKS	2	2	2	-	-
GREENWOOD	-	-	1	-	-
HARROGATE	-	-	1	-	-
HARROP	-	-	-	1	-
HOSMER	-	1	-	-	-
INVERMERE	-	-	1	3	-
KAMLOOPS	17	21	15	15	11
KASLO	-	1	-	1	-
KIMBERLEY	-	2	-	-	1
LAC LA HACHE	-	1	1	-	-
LAC LE JEUNE	1	-	-	-	-
LILLOOET	-	-	3	1	-
LISTER	-	-	1	-	-
LONE BUTTE	-	-	1	-	-

KAMLOOPS REGION CONT.	1998	1997	1996	1995	1994
LOWER NICOLA	1	-	-	-	-
LYTTON	-	-	-	2	2
MAGNA BAY	-	-	-	-	1
MERRITT	3	3	-	4	2
MIDWAY	-	1	-	-	-
MONTE LAKE	-	-	1	-	-
NAKUSP	-	1	-	-	1
NELSON	-	3	2	1	-
NEW DENVER	1	-	-	1	-
POTPOUR	1	-	-	-	-
PRITCHARD	1	-	-	-	-
QUEENS BAY	-	-	-	-	1
RADIUM HOT SPRINGS	-	1	-	-	1
RASPBERRY	-	-	-	1	-
REVELSTOKE	1	1	-	4	2
ROCK CREEK	-	1	-	-	-
ROSSLAND	-	-	2	-	1
SALMO	1	-	-	2	2
SALMON ARM	2	2	4	7	1
SICAMOUS	1	-	1	2	-
SILVERTON	-	-	1	-	-
SLOCAN	-	-	-	1	-
SORRENTO	-	1	-	-	1
SPARWOOD	-	-	-	-	2
SPENCES BRIDGE	-	-	-	1	-
SPILLIMACHEEN	-	-	-	-	1
TAPPEN	-	-	2	2	-
TATA CREEK	-	1	-	-	-
TRAIL	5	1	-	1	2
VINSULA	1	-	-	-	-
WARFIELD	1	-	-	-	-
WINLAW	-	-	-	1	1
WYCLIFF	-	-	1	-	-
YMIR	-	1	-	-	-
KELOWNA REGION	40	50	44	49	57
ALLISON LAKE	-	-	1	-	-
ARMSTRONG	1	-	1	1	1
BRIDESVILLE	-	-	-	-	1
COALMONT	-	-	-	1	-
ENDERBY	2	2	2	-	1
FALKLAND	-	-	-	1	-
FAULDER	-	1	-	-	-
HEDLEY	-	-	2	-	-
IDEAL LAKE	-	-	-	-	1
KALEDEN	-	-	-	1	-
KELOWNA	13	22	12	18	15
KEREMEOS	1	1	1	1	3
LAVINGTON	-	-	1	-	-
LUMBY	1	1	1	1	-
NARAMATA	-	-	-	2	1
OKANAGAN FALLS	-	-	-	-	1

KELOWNA REGION CONT.	1998	1997	1996	1995	1994
OLIVER	1	2	3	2	2
OSOYOOS	2	-	1	1	4
OYAMA	-	-	1	-	1
PEACHLAND	-	1	-	1	2
PENTICTON	4	4	8	5	10
PRINCETON	3	1	1	2	1
SALMON ARM	-	1	-	-	-
SUMMERLAND	3	1	-	-	3
VERNON	7	9	8	9	6
WESTBANK	1	2	1	3	1
WINFIELD	1	2	-	-	3
NANAIMO REGION	56	59	69	54	52
AHOUSAHT	-	1	-	-	1
ALERT BAY	-	1	-	-	1
BAMFIELD	-	-	1	-	-
BELLA COOLA	-	1	-	-	-
BLACK CREEK	-	-	1	-	1
BONANZA LAKE	-	-	1	-	-
BOWSER	-	-	-	-	1
CAMPBELL RIVER	5	4	8	2	6
CASSIDY	-	1	-	1	1
COAL HARBOUR	-	-	1	-	-
COMOX	2	1	3	2	7
CORTES ISLAND	-	1	-	-	-
COURTENAY	4	6	11	4	1
CUMBERLAND	1	2	1	1	-
DENMAN ISLAND	1	-	-	-	-
ERRINGTON	1	-	2	-	-
FANNY BAY	-	1	-	-	1
GABRIOLA ISLAND	1	-	-	-	1
GOLD RIVER	2	-	-	1	-
HAGENSBORG	-	-	-	-	1
HARWOOD ISLAND	-	-	-	1	-
HORNBY ISLAND	-	-	1	-	-
KLEMTU	-	-	-	-	1
KUPER ISLAND	-	-	-	-	1
KYUQUOT	-	1	-	-	-
LADYSMITH	4	3	3	1	-
LANTZVILLE	1	2	-	1	2
MASSET	1	-	1	1	-
MERVILLE	1	1	2	1	-
NANAIMO	8	16	15	11	9
NANOOSE	1	-	-	-	1
OPETCHESAHT	1	1	-	1	-
PARKSVILLE	2	-	3	4	3
PORT ALBERNI	6	5	8	8	4
PORT HARDY	3	2	1	-	-
PORT MCNEILL	1	-	2	-	-
POWELL RIVER	4	4	-	4	6
QUADRA ISLAND	-	-	1	-	1
QUALICUM BEACH	2	-	1	3	-

NANAIMO REGION CONT.	1998	1997	1996	1995	1994
QUEEN CHARLOTTE CITY	2	-	-	1	-
RIVERS INLET	-	1	1	-	-
SANDSPIT	-	-	-	1	-
SAYWARD	1	2	-	-	1
SOINTULA	-	-	-	1	-
TOFINO	-	1	-	1	-
UCLUELET	1	-	1	2	1
WOSS LAKE	-	1	-	-	-
ZEBALLOS	-	-	-	1	-
VICTORIA REGION	61	63	57	60	60
BRENTWOOD BAY	1	-	-	-	-
CHEMAINUS	1	3	-	3	-
COBBLE HILL	2	-	-	-	1
CROFTON	1	1	-	-	-
DUNCAN	9	6	5	7	3
ESQUIMALT	-	-	-	-	1
GALIANO ISLAND	-	-	-	-	1
GANGES	-	-	-	1	1
JORDAN RIVER	1	-	-	-	-
LAKE COWICHAN	-	1	1	2	-
LONG HARBOUR	-	-	-	-	1
MILL BAY	1	1	1	1	-
PORT RENFREW	-	-	1	1	1
SAANICH	-	-	2	1	-
SAANICHTON	1	-	1	-	-
SALTSPRING ISLAND	1	-	-	-	-
SAMUELS ISLAND	-	-	-	1	-
SATURNA ISLAND	-	1	-	-	-
SHAWNIGAN LAKE	1	-	-	-	2
SIDNEY	5	5	3	-	2
SOOKE	4	2	-	2	3
VICTORIA	33	43	42	41	44
YOUBOU	-	-	1	-	-
PRINCE GEORGE REGION	41	51	39	41	44
150 MILE HOUSE	-	-	-	1	-
ALEXIS CREEK	-	-	-	1	-
ALKALI LAKE	-	1	-	-	-
ATLIN	-	-	1	-	-
BIG CREEK	-	-	1	-	-
BROMAN LAKE	-	-	1	-	-
BURNS LAKE	1	1	-	1	1
CEDARVALE	-	-	1	-	-
CHETWYND	2	-	1	-	-
CLUCULZ LAKE	-	-	1	-	-
COLLINS BAY	-	-	1	-	-
DAWSON CREEK	2	3	3	4	3
DEASE LAKE	2	-	1	-	-
ENDAKO	-	-	-	-	1
FORT FRASER	-	-	1	-	-
FORT NELSON	-	-	1	-	1
FORT ST. JAMES	1	1	3	-	1

KELOWNA REGION CONT.	1998	1997	1996	1995	1994
OLIVER	1	2	3	2	2
OSOYOOS	2	-	1	1	4
OYAMA	-	-	1	-	1
PEACHLAND	-	1	-	1	2
PENTICTON	4	4	8	5	10
PRINCETON	3	1	1	2	1
SALMON ARM	-	1	-	-	-
SUMMERLAND	3	1	-	-	3
VERNON	7	9	8	9	6
WESTBANK	1	2	1	3	1
WINFIELD	1	2	-	-	3
NANAIMO REGION	56	59	69	54	52
AHOUSAHT	-	1	-	-	1
ALERT BAY	-	1	-	-	1
BAMFIELD	-	-	1	-	-
BELLA COOLA	-	1	-	-	-
BLACK CREEK	-	-	1	-	1
BONANZA LAKE	-	-	1	-	-
BOWSER	-	-	-	-	1
CAMPBELL RIVER	5	4	8	2	6
CASSIDY	-	1	-	1	1
COAL HARBOUR	-	-	1	-	-
COMOX	2	1	3	2	7
CORTES ISLAND	-	1	-	-	-
COURTENAY	4	6	11	4	1
CUMBERLAND	1	2	1	1	-
DENMAN ISLAND	1	-	-	-	-
ERRINGTON	1	-	2	-	-
FANNY BAY	-	1	-	-	1
GABRIOLA ISLAND	1	-	-	-	1
GOLD RIVER	2	-	-	1	-
HAGENSBORG	-	-	-	-	1
HARWOOD ISLAND	-	-	-	1	-
HORNBY ISLAND	-	-	1	-	-
KLEMTU	-	-	-	-	1
KUPER ISLAND	-	-	-	-	1
KYUQUOT	-	1	-	-	-
LADYSMITH	4	3	3	1	-
LANTZVILLE	1	2	-	1	2
MASSET	1	-	1	1	-
MERVILLE	1	1	2	1	-
NANAIMO	8	16	15	11	9
NANOOSE	1	-	-	-	1
OPETCHESAHT	1	1	-	1	-
PARKSVILLE	2	-	3	4	3
PORT ALBERNI	6	5	8	8	4
PORT HARDY	3	2	1	-	-
PORT MCNEILL	1	-	2	-	-
POWELL RIVER	4	4	-	4	6
QUADRA ISLAND	-	-	1	-	1
QUALICUM BEACH	2	-	1	3	-

NANAIMO REGION CONT.	1998	1997	1996	1995	1994
QUEEN CHARLOTTE CITY	2	-	-	1	-
RIVERS INLET	-	1	1	-	-
SANDSPIT	-	-	-	1	-
SAYWARD	1	2	-	-	1
SOINTULA	-	-	-	1	-
TOFINO	-	1	-	1	-
UCLUELET	1	-	1	2	1
WOSS LAKE	-	1	-	-	-
ZEBALLOS	-	-	-	1	-
VICTORIA REGION	61	63	57	60	60
BRENTWOOD BAY	1	-	-	-	-
CHEMAINUS	1	3	-	3	-
COBBLE HILL	2	-	-	-	1
CROFTON	1	1	-	-	-
DUNCAN	9	6	5	7	3
ESQUIMALT	-	-	-	-	1
GALIANO ISLAND	-	-	-	-	1
GANGES	-	-	-	1	1
JORDAN RIVER	1	-	-	-	-
LAKE COWICHAN	-	1	1	2	-
LONG HARBOUR	-	-	-	-	1
MILL BAY	1	1	1	1	-
PORT RENFREW	-	-	1	1	1
SAANICH	-	-	2	1	-
SAANICHTON	1	-	1	-	-
SALTSPRING ISLAND	1	-	-	-	-
SAMUELS ISLAND	-	-	-	1	-
SATURNA ISLAND	-	1	-	-	-
SHAWNIGAN LAKE	1	-	-	-	2
SIDNEY	5	5	3	-	2
SOOKE	4	2	-	2	3
VICTORIA	33	43	42	41	44
YIOUBOU	-	-	1	-	-
PRINCE GEORGE REGION	41	51	39	41	44
150 MILE HOUSE	-	-	-	1	-
ALEXIS CREEK	-	-	-	1	-
ALKALI LAKE	-	1	-	-	-
ATLIN	-	-	1	-	-
BIG CREEK	-	-	1	-	-
BROMAN LAKE	-	-	1	-	-
BURNS LAKE	1	1	-	1	1
CEDARVALE	-	-	1	-	-
CHETWYND	2	-	1	-	-
CLUCULZ LAKE	-	-	1	-	-
COLLINS BAY	-	-	1	-	-
DAWSON CREEK	2	3	3	4	3
DEASE LAKE	2	-	1	-	-
ENDAKO	-	-	-	-	1
FORT FRASER	-	-	1	-	-
FORT NELSON	-	-	1	-	1
FORT ST. JAMES	1	1	3	-	1

PRINCE GEORGE REGION CONT.	1998	1997	1996	1995	1994
FORT ST. JOHN	1	-	1	4	4
FRASER LAKE	-	1	-	-	-
HARTLEY BAY	-	1	-	-	-
HAZELTON	1	-	-	1	-
HIXON	1	-	-	-	-
HORSEFLY	-	-	1	-	-
HOUSTON	-	-	1	-	1
HUDSON'S HOPE	-	1	-	-	-
ISKUT	1	-	-	-	-
KISPIX	-	1	-	-	-
KITIMAT	1	2	-	1	2
KITKATLA	-	-	-	-	1
KITWANGA	-	-	-	1	1
LAX KW'ALAMMS	1	-	-	-	-
LIKELY	1	-	-	1	-
MACKENZIE	-	2	-	2	-
MCBRIDE	-	-	-	1	-
MCLEESE LAKE	-	1	-	-	1
MCLEOD LAKE	-	-	-	-	1
MORICETOWN	-	-	-	1	-
NEMIAH VALLEY	-	1	-	-	-
NEW HAZELTON	-	1	-	-	1
PENNY	-	-	-	-	1
PORCHER ISLAND	-	-	-	1	-
PORT SIMPSON	-	1	-	-	1
PRINCE GEORGE	9	10	9	7	12
PRINCE RUPERT	2	2	1	1	3
QUESNEL	3	7	3	4	1
SMITHERS	2	-	1	1	1
SODA CREEK	-	1	-	-	-
TAYLOR	1	1	-	-	-
TERRACE	4	4	3	3	1
TSEH KEY DENE	-	1	-	-	-
TUMBLER RIDGE	-	-	-	1	-
VALEMOUNT	-	-	2	-	1
VANDERHOOF	1	1	-	1	1
WILLIAMS LAKE	4	6	1	3	3
TOTAL BRITISH COLUMBIA	511	582	557	534	513

PRINCE GEORGE REGION CONT.	1998	1997	1996	1995	1994
FORT ST. JOHN	1	-	1	4	4
FRASER LAKE	-	1	-	-	-
HARTLEY BAY	-	1	-	-	-
HAZELTON	1	-	-	1	-
HIXON	1	-	-	-	-
HORSEFLY	-	-	1	-	-
HOUSTON	-	-	1	-	1
HUDSON'S HOPE	-	1	-	-	-
ISKUT	1	-	-	-	-
KISPLOX	-	1	-	-	-
KITIMAT	1	2	-	1	2
KITKATLA	-	-	-	-	1
KITWANGA	-	-	-	1	1
LAX KW'ALAMMS	1	-	-	-	-
LIKELY	1	-	-	1	-
MACKENZIE	-	2	-	2	-
MCBRIDE	-	-	-	1	-
MCLEESE LAKE	-	1	-	-	1
MCLEOD LAKE	-	-	-	-	1
MORICETOWN	-	-	-	1	-
NEMIAH VALLEY	-	1	-	-	-
NEW HAZELTON	-	1	-	-	1
PENNY	-	-	-	-	1
PORCHER ISLAND	-	-	-	1	-
PORT SIMPSON	-	1	-	-	1
PRINCE GEORGE	9	10	9	7	12
PRINCE RUPERT	2	2	1	1	3
QUESNEL	3	7	3	4	1
SMITHERS	2	-	1	1	1
SODA CREEK	-	1	-	-	-
TAYLOR	1	1	-	-	-
TERRACE	4	4	3	3	1
TSEH KEY DENE	-	1	-	-	-
TUMBLER RIDGE	-	-	-	1	-
VALEMOUNT	-	-	2	-	1
VANDERHOOF	1	1	-	1	1
WILLIAMS LAKE	4	6	1	3	3
TOTAL BRITISH COLUMBIA	511	582	557	534	513

ILLICIT DRUG OVERVIEW

In June 1993, the Minister of Health and the Attorney General of British Columbia announced in the Legislature the appointment of the Chief Coroner to head up a task force to inquire into what appeared to be an inordinately high number of deaths associated with the illicit use of heroin. Deaths due to the use of illicit drugs became an epidemic in British Columbia, increasing from 39 deaths in 1988 to 361 in 1993, as highlighted by the following statistics:

B.C. Illicit Drug Deaths

Year	# of deaths
1988	39
1989	67
1990	82
1991	124
1992	164
1993	361
1994	317
1995	224
1996	312
1997	310
1998	413

This table represents the number of non-therapeutic (illicit) drug deaths in B.C., where the CAUSE OF DEATH was due to, or as a consequence of, a DRUG OVERDOSE. This category includes cocaine, heroin, and illicitly purchased methadone. This table does NOT include cases where illicit drugs may have contributed to but were not the cause of death.

Illicit Drug Deaths by Age/Sex

	1998	1997	1996	1995	1994	1993	1992	1991	1990	1989
<=20 yrs	10	6	16	6	8	9	3	3	0	2
21 - 30	72	61	77	57	71	63	40	33	29	18
31 - 40	171	141	130	96	165	192	80	58	42	37
41 - 50	123	81	74	52	60	79	31	20	9	8
51 - 60	35	17	11	11	10	13	8	8	2	2
Over 60 yrs	2	4	4	2	2	5	2	2	0	0
Total	413	310	312	224	317*	361	164	124	82	67
 Male	 341	 266	 255	 192	 267	 295	 136	 97	 66	 52
Female	72	44	57	32	50	66	28	27	16	15

* One case for 1994 for which age undetermined.

Illicit Drugs by Township

	1998	1997	1996	1995	1994	1993	1992
FRASER VALLEY REGION	25	23	13	11	7	13	5
ABBOTSFORD	6	8	8	4	1	2	2
AGASSIZ	1	1	1	-	-	2	1
CHILLIWACK	7	6	1	4	3	5	1
CULTUS LAKE	-	-	-	1	-	-	-
FORT LANGLEY	-	1	-	-	-	-	-
HARRISON MILLS	-	1	-	-	-	1	-
HOPE	-	1	2	1	-	1	-
LANGLEY	3	-	-	-	-	-	-
MAPLE RIDGE	4	-	-	-	-	-	-
MISSION	4	3	1	1	2	2	1
NORTH BEND	-	1	-	-	-	-	-
SARDIS	-	1	-	-	1	-	-
NEW WESTMINSTER REGION	77	67	62	43	63	49	38
ALDERGROVE	-	-	1	-	1	-	-
BURNABY	20	13	15	8	10	10	9
COQUITLAM	9	4	3	4	6	3	4
DELTA	2	5	2	2	-	1	-
LANGLEY	-	-	4	1	1	1	-
MAPLE RIDGE	-	-	1	2	1	2	1
NEW WESTMINSTER	3	16	11	10	23	8	4
PORT COQUITLAM	3	2	1	1	1	2	2
PORT MOODY	1	1	2	-	-	-	-
RICHMOND	7	3	4	2	3	4	7
SURREY	31	23	17	13	16	17	11
WHITE ROCK	1	-	1	-	1	1	-
VANCOUVER REGION	199	148	163	123	167	204	96
GIBSONS	-	-	1	1	-	-	1
LIONS BAY	-	-	-	-	1	-	-
NORTH VANCOUVER	5	6	7	4	4	2	3
PENDER HARBOUR	-	-	-	1	-	-	-
ROBERTS CREEK	1	-	-	-	-	-	-
SECHelt	-	-	-	1	-	-	-
SQUAMISH	2	2	-	-	-	-	1
VANCOUVER	191	140	151	116	160	201	91
WEST VANCOUVER	-	-	2	-	1	1	-
WHISTLER	-	-	2	-	1	-	-
NANAIMO REGION	30	23	18	15	27	22	13
ALERT BAY	-	-	-	-	1	-	-
CAMPBELL RIVER	9	2	3	3	2	7	7
CEDAR	-	-	-	-	1	1	-
COMOX	-	-	-	-	2	1	1
COOMBS	-	-	1	-	-	-	-
COURTENAY	4	5	4	1	2	-	-
CUMBERLAND	-	-	1	-	-	-	-
DRURY INLET	-	-	1	-	-	-	-
LADYSMITH	-	2	-	-	3	-	-
LANTZVILLE	1	-	-	-	-	-	-
NANAIMO	7	10	3	6	12	10	3
PARKSVILLE	1	-	-	-	-	1	-
PORT ALBERNI	3	1	4	1	2	-	-
PORT CLEMENTS	-	-	-	1	-	-	-
PORT HARDY	-	2	-	1	-	1	-
POWELL RIVER	4	-	1	1	1	1	1
ROYSTON	-	-	-	-	1	-	-
SANDSPIT	1	-	-	-	-	-	-



Illicit Drugs by Township

	1998	1997	1996	1995	1994	1993	1992
FRASER VALLEY REGION	25	23	13	11	7	13	5
ABBOTSFORD	6	8	8	4	1	2	2
AGASSIZ	1	1	1	-	-	2	1
CHILLIWACK	7	6	1	4	3	5	1
CULTUS LAKE	-	-	-	1	-	-	-
FORT LANGLEY	-	1	-	-	-	-	-
HARRISON MILLS	-	1	-	-	-	1	-
HOPE	-	1	2	1	-	1	-
LANGLEY	3	-	-	-	-	-	-
MAPLE RIDGE	4	-	-	-	-	-	-
MISSION	4	3	1	1	2	2	1
NORTH BEND	-	1	-	-	-	-	-
SARDIS	-	1	-	-	1	-	-
NEW WESTMINSTER REGION	77	67	62	43	63	49	38
ALDERGROVE	-	-	1	-	1	-	-
BURNABY	20	13	15	8	10	10	9
COQUITLAM	9	4	3	4	6	3	4
DELTA	2	5	2	2	-	1	-
LANGLEY	-	-	4	1	1	1	-
MAPLE RIDGE	-	-	1	2	1	2	1
NEW WESTMINSTER	3	16	11	10	23	8	4
PORT COQUITLAM	3	2	1	1	1	2	2
PORT MOODY	1	1	2	-	-	-	-
RICHMOND	7	3	4	2	3	4	7
SURREY	31	23	17	13	16	17	11
WHITE ROCK	1	-	1	-	1	1	-
VANCOUVER REGION	199	148	163	123	167	204	96
GIBSONS	-	-	1	1	-	-	1
LIONS BAY	-	-	-	-	1	-	-
NORTH VANCOUVER	5	6	7	4	4	2	3
PENDER HARBOUR	-	-	-	1	-	-	-
ROBERTS CREEK	1	-	-	-	-	-	-
SECHLT	-	-	-	1	-	-	-
SQUAMISH	2	2	-	-	-	-	1
VANCOUVER	191	140	151	116	160	201	91
WEST VANCOUVER	-	-	2	-	1	1	-
WHISTLER	-	-	2	-	1	-	-
NANAIMO REGION	30	23	18	15	27	22	13
ALERT BAY	-	-	-	-	1	-	-
CAMPBELL RIVER	9	2	3	3	2	7	7
CEDAR	-	-	-	-	1	1	-
COMOX	-	-	-	-	2	1	1
COOMBS	-	-	1	-	-	-	-
COURTENAY	4	5	4	1	2	-	-
CUMBERLAND	-	-	1	-	-	-	-
DRURY INLET	-	-	1	-	-	-	-
LADYSMITH	-	2	-	-	3	-	-
LANTZVILLE	1	-	-	-	-	-	-
NANAIMO	7	10	3	6	12	10	3
PARKSVILLE	1	-	-	-	-	1	-
PORT ALBERNI	3	1	4	1	2	-	-
PORT CLEMENTS	-	-	-	1	-	-	-
PORT HARDY	-	2	-	1	-	1	-
POWELL RIVER	4	-	1	1	1	1	1
ROYSTON	-	-	-	-	1	-	-
SANDSPIT	1	-	-	-	-	-	-

	1998	1997	1996	1995	1994	1993	1992
SAYWARD	-	-	-	-	-	-	1
SKIDEGATE	-	-	-	1	-	-	-
UCLUELET	-	1	-	-	-	-	-
VICTORIA REGION	28	20	24	16	20	33	6
BRENTWOOD BAY	1	-	-	-	-	-	-
DUNCAN	-	2	-	-	1	1	-
ESQUIMALT	-	-	-	-	1	1	-
GANGES	-	-	-	-	-	1	-
LAKE COWICHAN	-	-	-	1	-	-	-
METCHOSIN	-	-	1	-	-	-	-
SALT SPRING ISLAND	-	1	-	-	-	-	-
SHAWNIGAN LAKE	1	-	-	-	-	-	-
SIDNEY	-	-	-	-	-	-	1
SOOKE	-	-	-	-	-	-	1
VICTORIA	26	17	23	15	18	30	4
KAMLOOPS REGION	22	11	12	10	13	8	3
100 MILE HOUSE	-	-	1	-	-	1	-
BARRIERE	-	-	-	-	-	-	1
CACHE CREEK	-	-	-	1	-	-	-
CASTLEGAR	3	1	-	-	-	-	-
CHASE	-	-	-	-	-	1	-
CLEARWATER	-	-	-	-	1	-	-
CRANBROOK	1	-	2	-	1	1	-
FOREST GROVE	1	-	-	-	-	-	-
FRUITVALE	-	-	-	1	-	-	-
KAMLOOPS	12	10	6	6	10	3	1
LOGAN LAKE	1	-	-	-	-	-	-
MCLURE	-	-	-	1	-	-	-
MERRITT	1	-	2	-	-	-	1
MONTE LAKE	-	-	1	-	-	-	-
ROSSLAND	-	-	-	-	1	-	-
SALMON ARM	1	-	-	-	-	-	-
TRAIL	1	-	-	1	-	1	-
WARFIELD	1	-	-	-	-	-	-
WINLAW	-	-	-	-	-	1	-
KELOWNA REGION	14	6	7	1	9	7	1
ENDERBY	2	-	-	-	-	-	-
KELOWNA	4	4	2	-	2	3	-
LUMBY	-	-	-	-	-	2	-
OSOYOOS	-	-	-	-	-	1	-
OYAMA	1	-	-	-	-	-	-
PENTICTON	1	-	1	-	2	-	1
VERNON	6	2	4	1	4	1	-
WESTBANK	-	-	-	-	1	-	-
PRINCE GEORGE REGION	18	12	13	5	11	25	2
CHETWYND	2	-	-	1	-	-	-
CLINTON	1	-	-	-	-	-	-
DAWSON CREEK	2	-	-	-	-	-	-
FORT ST. JOHN	1	2	1	-	-	1	-
HIXON	-	1	-	-	-	-	-
KITIMAT	-	-	-	-	-	1	-
LOVEL COVE	-	-	-	1	-	-	-
MACKENZIE	-	-	1	-	-	-	-
PRINCE GEORGE	7	4	7	1	9	13	1
PRINCE RUPERT	1	3	3	2	1	10	1
QUESNEL	2	-	-	-	1	-	-
TERRACE	2	1	-	-	-	-	-
WILLIAMS LAKE	-	1	1	-	-	-	-

Illicit Drug Deaths by Day of the Week & Week of Month (1998)

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1 st	8	15	8	11	15	16	13
2 nd	16	10	9	17	13	19	11
3 rd	7	11	11	11	15	16	16
4 th	12	9	17	23	18	12	12
5 th	4	1	3	9	12	5	9

	1998	1997	1996	1995	1994	1993	1992
SAYWARD	-	-	-	-	-	-	1
SKIDEGATE	-	-	-	1	-	-	-
UCLUELET	-	1	-	-	-	-	-
VICTORIA REGION	28	20	24	16	20	33	6
BRENTWOOD BAY	1	-	-	-	-	-	-
DUNCAN	-	2	-	-	1	1	-
ESQUIMALT	-	-	-	-	1	1	-
GANGES	-	-	-	-	-	1	-
LAKE COWICHAN	-	-	-	1	-	-	-
METCHOSIN	-	-	1	-	-	-	-
SALT SPRING ISLAND	-	1	-	-	-	-	-
SHAWNIGAN LAKE	1	-	-	-	-	-	-
SIDNEY	-	-	-	-	-	-	1
SOOKE	-	-	-	-	-	-	1
VICTORIA	26	17	23	15	18	30	4
KAMLOOPS REGION	22	11	12	10	13	8	3
100 MILE HOUSE	-	-	1	-	-	1	-
BARRIERE	-	-	-	-	-	-	1
CACHE CREEK	-	-	-	1	-	-	-
CASTLEGAR	3	1	-	-	-	-	-
CHASE	-	-	-	-	-	1	-
CLEARWATER	-	-	-	-	1	-	-
CRANBROOK	1	-	2	-	1	1	-
FOREST GROVE	1	-	-	-	-	-	-
FRUITVALE	-	-	-	1	-	-	-
KAMLOOPS	12	10	6	6	10	3	1
LOGAN LAKE	1	-	-	-	-	-	-
MCLURE	-	-	-	1	-	-	-
MERRITT	1	-	2	-	-	-	1
MONTE LAKE	-	-	1	-	-	-	-
ROSSLAND	-	-	-	-	1	-	-
SALMON ARM	1	-	-	-	-	-	-
TRAIL	1	-	-	1	-	1	-
WARFIELD	1	-	-	-	-	-	-
WINLAW	-	-	-	-	-	1	-
KELOWNA REGION	14	6	7	1	9	7	1
ENDERBY	2	-	-	-	-	-	-
KELOWNA	4	4	2	-	2	3	-
LUMBY	-	-	-	-	-	2	-
OSOYOOS	-	-	-	-	-	1	-
OYAMA	1	-	-	-	-	-	-
PENTICTON	1	-	1	-	2	-	1
VERNON	6	2	4	1	4	1	-
WESTBANK	-	-	-	-	1	-	-
PRINCE GEORGE REGION	18	12	13	5	11	25	2
CHETWYND	2	-	-	1	-	-	-
CLINTON	1	-	-	-	-	-	-
DAWSON CREEK	2	-	-	-	-	-	-
FORT ST. JOHN	1	2	1	-	-	1	-
HIXON	-	1	-	-	-	-	-
KITIMAT	-	-	-	-	-	1	-
LOVEL COVE	-	-	-	1	-	-	-
MACKENZIE	-	-	1	-	-	-	-
PRINCE GEORGE	7	4	7	1	9	13	1
PRINCE RUPERT	1	3	3	2	1	10	1
QUESNEL	2	-	-	-	1	-	-
TERRACE	2	1	-	-	-	-	-
WILLIAMS LAKE	-	1	1	-	-	-	-

Illicit Drug Deaths by Day of the Week & Week of Month (1998)

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1 st	8	15	8	11	15	16	13
2 nd	16	10	9	17	13	19	11
3 rd	7	11	11	11	15	16	16
4 th	12	9	17	23	18	12	12
5 th	4	1	3	9	12	5	9

INQUEST STATISTICS (1998)

Classification of Death

Natural	12
Accident	9
Suicide	5
Homicide	1
Undetermined	3

Type of Death

Police Custody/Lockup

Federal Correctional Facility	11
Police Cell Lock-up	4
Police Custody	6
Police Shooting	2

Industrial	3
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Medical	2
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Other	2
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TOTAL	30
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Summary of Inquest Recommendations & Responses

In 1998, the Coroners Service held 30 inquests. The following summaries are brief indicators of the subject matter of the inquests, the juries' recommendations and the responses received at the time of writing. The case histories are not based on transcript information and, therefore, do not definitively represent evidence as presented at these inquests.

Inquest No. 1 (*Police Shooting*)

On January 26, 1998, an inquest was held at Burnaby, B.C. into the death of a 64-year-old male who died on August 28th, 1996 of a gunshot wound.

The subject was the target of an undercover drug operation, during which a police firearm was discharged. Testimony at inquest revealed that the subject was regarded by police as a potentially violent and dangerous individual. Evidence was presented at inquest as to potential difficulties with "staging" of a handgun and various training programs in place for police officers regarding the handling of a handgun.

The jury found that the death resulted from a gunshot wound and classified the death as an accident.

The recommendations of the jury, which were forwarded to the Attorney General, were as follows:

1. That the Attorney General cause an investigation to occur into the feasibility and

practicality of changing the "at the ready" position to placing the trigger finger below the trigger guard.

2. Training for all types and levels of firearms to include all pertinent information, as known, into the action characterized as the "sympathetic nervous syndrome" or the "involuntary clutching action".

Response:

1. The Attorney General responded that the Police Academy, Justice Institute of British Columbia is responsible for the training of all municipal police in B.C. As part of the firearms training, the Academy currently trains officers to place the index finger along the frame of the gun. A copy of the jury's recommendations were forwarded to the Police Academy to review the practicality of placing the trigger finger below the trigger guard.
2. The training provided by the Police Academy does extensively cover the action characterized as the "sympathetic nervous syndrome" or the "involuntary clutching action".

Inquest No. 2 (*Correctional Facility*)

On February 6, 1998, an inquest was held at Mission, B.C. into the death of a 50-year-old male who died on January 16, 1997 at Mission Memorial Hospital.

The subject was an inmate incarcerated at Mission Institute. Evidence at inquest indicated that the subject had a lengthy history of alcohol and drug abuse. He was found in his cell, apparently without a pulse. Nursing personnel administered Narcan and cardiac resuscitation. However, the subject was pronounced dead at hospital.

The jury found that the death resulted from a heroin overdose and classified the death as a suicide.

The recommendation of the jury, which was forwarded to Correctional Services Canada, was as follows:

1. Inmates should be checked on regularly, especially when their actions are inconsistent with established behaviour.

Response:

1. Correctional Services Canada responded that the inquest and recommendations were discussed at a general staff meeting at Mission Institute. In addition, a bulletin was posted on the Institutional SIN news for a period of two weeks which reminded all "work supervisors to ensure they follow-up with unit staff when inmates do not report to work".

Inquest No. 3 (Other)

On March 2, 1998, an inquest was held at Burnaby, B.C. into the death of a 61-year-old male who died on October 25, 1996 at Mt. St. Joseph's Hospital in Vancouver.

The subject was found collapsed outside his residence. He had been drinking heavily. After examination by EHS, the subject was taken by police to the Vancouver Detox Centre, where he was later discharged. The subject remained near the Detox Centre, and because of concerns due to his condition, was taken by ambulance to hospital.

The jury found that death resulted from cerebral infarction as a result of a natural disease process.

The recommendations of the jury, which were forwarded to Ministry of Health and Vancouver Detox Centre, were as follows:

Ministry of Health

1. CT scanners be installed in acute care hospitals, in particular Mt. St. Joseph's Hospital.
2. Increase hospital staff to correspond to work level of patient care at Mt. St. Joseph's.

Vancouver Detox Centre

1. The Vancouver Detox Centre send all relevant documents concerning the patient when the patient is sent to hospital for treatment.
2. That the Detox Centre provides hygienic amenities to admitted patients.

Response:

Vancouver Detox Centre

1. The Vancouver Detox Centre responded that both recommendations have been implemented.

Ministry of Health

1. The Vancouver/Richmond Health Board is undertaking a major review called the Review of Acute and Rehab Services. This review is examining many health care delivery issues, including emergency services. The Vancouver Catholic Healthcare Group will examine the role and function of the Mount Saint Joseph ER, including operating hours and staffing.

Inquest No. 4 (Medical - Mental Health)

On March 16, 1998, an inquest was held at Victoria, B.C. into the death of a 49-year-old female who died on May 30, 1997 in Victoria, B.C.

The subject was stabbed by her 24-year-old son, who was suffering from schizophrenia. Issues exist around facilities available for schizophrenics on discharged from hospital.

The jury found that death resulted from a stab wound to back of chest and classified the death as homicide.

The recommendations of the jury, which were forwarded to the Premier and Minister Responsible for Youth, the Minister of Finance and Corporate Relations, the Ministry of Health - Adult Mental Health Division, the Minister of Health, the Attorney General, Pharmacare, the British Columbia Medical Association, and the College of Physicians and Surgeons, were as follows:

Premier and Minister Responsible for Youth

1. The guardianship legislation presently waiting for proclamation be proclaimed as soon as possible.

Minister of Health, Health Regions, Ministry of Health - Adult Mental Health Division, Ministry of Finance and Corporate Relations

1. That immediate funding be provided for the establishment of a day hospital in Victoria for psychiatric patients.
2. That immediate funding be provided for reconfiguration and staffing of emergency admission facilities at local area hospitals to provide suitable care for those suffering from psychiatric illness.
3. That immediate funding be provided to permit assertive early intervention and treatment for those suffering from psychotic illness, including schizophrenia.
4. That the proposal for the Early Schizophrenia Program to include education to physicians

be implemented under the Mental Health Plan.

5. That immediate funding be provided for increasing the number of beds in the Eric Martin Pavilion and other psychiatric facilities throughout the province.
6. That Emergency Mental Health Services' staffing be increased to support a 24-hour, 7 days per week service and psychiatric consultation.
7. That the efforts in place to create an integrated database for mental health patients in the Capital Health Region be expedited.
8. That the Policies and Procedures Regarding Sharing of Client Records between Mental Health, Alcohol and Drugs and Forensic Psychiatric Services and families be distributed to all public bodies.
9. That guidelines to the Mental Health Review Panel and the review board be revised from the 1991 guidelines to reflect the McCorkell decision.
10. That the staff of Eric Martin Pavilion and private physicians be educated on community-based resources and how to access them.
11. That increased funding be directed to public education of serious mental illnesses, including schizophrenia and psychotic illnesses.
12. Immediate and increased funding be provided to British Columbia Schizophrenia Society for public education, etc.
13. That the communication of information relating to the mental health client who is resisting treatment or demonstrates a lack of insight into his/her illness, needs to include all agencies who are providing direct client services.

14. In order to enhance integration of mental health services, further effort to define and coordinate related services in the Capital Health Region is required.

15. That the Capital Health Region study and consider implementation of a computer information system, as presently in use in Kelowna, B.C., to link medical and psychiatric providers of services to the public.

Ministry of Health - Adult Mental Health Division

1. That the Mental Health Information Services phone number be listed in the B.C. Government blue pages.
2. That Emergency Mental Health Services continue to develop working relationships and educate other caregivers in access and use of emergency services.
3. That Emergency Mental Health Services workers provide face-to-face outreach and follow-up with patients when alerts are given.
4. Ensure a review of Eric Martin Pavilion and similar health care institutions' policy to facilitate the redirection of psychiatric patients from judicial institutions to mental health care.

Minister of Health

1. That the Minister of Health establishes a website detailing the nature and scope of public, private and volunteer services available for the mentally ill.
2. That a mental health emergency phone service be established on a 24-hour basis.
3. Provide a regional capacity for forensic psychiatric cases.

Attorney General

1. Psychiatric assessments should be given a higher priority in the courts.

Attorney General, Minister of Health

1. That a review be conducted of interface between the criminal justice system and the mental health system with a view to establishing a diversion program for those suffering from mental illness to ensure that people in the justice system are not denied mental health care.

Minister of Health, Pharmacare

1. That restrictions on new clinically proven medications for treating schizophrenia be removed to allow the treating physicians to prescribe the most appropriate medication.

British Columbia Medical Association

1. That family physicians develop protocols to ensure involvement in all phases of the patient's psychiatric care and continued liaison between Emergency Mental Health Services' outreach and family physicians.

College of Physicians and Surgeons

1. That the College review the provisions of s.33 of the *Freedom of Information and Protection of Privacy Act* and the Ministry of Health's policy on confidential information and any changes to the College's position on the confidentiality of patient records as recommended.

The responses to the recommendations have not been summarized here due to their length.

Inquest No. 5 (Police Custody)

On March 24, 1998, an inquest was held at Burnaby, B.C. into the death of a 34-year-old male who died on August 31, 1997 at St. Paul's Hospital in Vancouver.

Police and ambulance were dispatched to the subject's residence where they found him behaving in a violent and irrational manner. The subject was restrained for his transfer to the hospital, as he continued to struggle violently. Minutes later, he was found not to be breathing. The restraints were removed and CPR was commenced. However, the subject was pronounced deceased at hospital.

The jury found that the cause of death was agitated delirium state as a result of acute cocaine intoxication and classified the death as an accident.

The jury made no recommendations.

Inquest No. 6 (Correctional Facility)

On March 27, 1998, an inquest was held at Mission, B.C. into the death of a 39-year-old male who died on May 15, 1997 at Mission Institute. The subject had a history of intravenous substance abuse and was found unresponsive in his cell.

The jury found that death resulted from a mixed drug overdose (heroin, cocaine & Valium) and classified the death as an accident.

The recommendations of the jury, which were forwarded to Correctional Service of Canada, were as follows:

1. Each prison have their own drug dog on the premises.
2. Additional staff required in the medical unit.

3. Additional staffing of guards in the prisoner unit.

Response:

Correctional Services of Canada

1. There are no plans at the present time for each institution to have its own drug dog but most regions have entered into agreements with companies and other ministries to provide the services of a drug dog on demand. Facilities not benefiting from these services have been encouraged to try and secure them through the use of outside contracts. In addition to drug dogs, facilities can use other tools such as: portable x-ray machines, ioscans and ionizers, urinalysis testing, interception tools and dynamic security practices.
2. The Solicitor General of Canada announced that the Correctional Services of Canada will be hiring 1000 new correctional officers over the next three years.

Inquest No. 7 (Correctional Facility)

On March 30, 1998, an inquest was held at Abbotsford, B.C. into the death of a 53-year-old male who died on October 31, 1997 at Matsqui Institution in Abbotsford.

The jury found that death resulted from lung cancer and classified the death as natural.

The jury had no recommendations.

Inquest No. 8 (Correctional Facility)

On April 2, 1998, an inquest was held at Abbotsford, B.C. into the death of a 52-year-old male who died on October 23, 1997 at Mountain Institution in Agassiz.

The jury found that the cause of death was cardiorespiratory arrest as a result of lung cancer and classified the death as natural.

The jury made no recommendations.

Inquest No. 9 (Police Custody)

On April 29, 1998, an inquest was held at Burnaby, B.C. into the death of a 39-year-old male who died on November 28, 1997 at Surrey, B.C.

The subject was observed outside his residence in a frenzied state. The RCMP were called, handcuffed the subject and waited for an ambulance. Prior to the ambulance arriving, the subject appeared to stop breathing. He was pronounced dead by EHS shortly thereafter.

The jury found that death resulted from restraint-associated asphyxia due to acute cocaine intoxication as a result of self-administration of i.v. cocaine and classified the death as an accident.

The jury made no recommendations.

Inquest No. 10 (Police Custody)

On April 30, 1998, an inquest was held at Surrey, B.C. into the death of a 34-year-old male who died on November 27, 1997 at Surrey Memorial Hospital.

The subject was handcuffed and transported to hospital by police after they were called to assist a motel owner. The subject was described as being frenzied. At hospital, he was restrained again as he remained combative and noisy. The subject later died after going into cardiac arrest.

The jury found that death resulted from cardiac dysrhythmia as a result of acute cocaine ingestion and classified the death as an accident.

The jury made no recommendations.

Inquest No. 11 (Police Cell)

On May 20th, 1998, an inquest was held at Burnaby, B.C. into the death of a 43-year-old male who died on March 13, 1997 at Surrey Memorial Hospital.

The subject was taken into custody due to a breach of probation and detained at the Surrey Pretrial Centre. The subject's health deteriorated and he was admitted to hospital under guard.

The jury found that death resulted from cardiomyopathy and metastatic cancer and classified the death as natural.

The jury made no recommendations.

Inquest No. 12 (Industrial)

On June 1, 1998, an inquest was held at Powell River, B.C. into the death of a 23-year-old male, who died on September 4, 1997 at Powell River, B.C.

The subject was working as a faller at a heli-logging site. He suffered an unwitnessed fatal injury when the log he was bucking destabilized and rolled overtop of him.

The jury found that death resulted from massive right hemothorax due to a crush injury of the chest and classified the death as accidental.

The recommendations of the jury forwarded to the Workers' Compensation Board, the Ministry of Forests, the Council of Forest Industries, were as follows:

Workers' Compensation Board

1. Faller certification as described in the Occupational Health and Safety Regulations (OHS) is required immediately.
2. WCB should clearly advise all employers of fallers and buckers of the new OHS regulations.
3. In any remote active logging operation, there be no less than two first aid attendants as defined by the regulations.
4. Personal alarm signal devices should be required as a complement to the existing safety gear of fallers/buckers.
5. Man checks should be made every 10-15 minutes.
6. Effective radio communication to be worn by all fallers/buckers.
7. Radio communication with helicopters must be maintained at all times in remote areas where falling and bucking activities are occurring.

Ministry of Forests, Council of Forest Industries and individual forest companies

1. Increased formal training by faller/bucker forest engineers, as well as increased use of experienced fallers/buckers in difficult sites.
2. Logging contractors, logging companies and the Ministry of Forests should work diligently to get logging permits ahead. This will improve workforce and safety program continuity.

Responses:

Workers' Compensation Board

1. The Board is in the process of developing a faller certification program with a targeted implementation date of April 15, 1999.
2. The Board has a new sheet called Access that it routinely sends out with assessment notices. All employers have been advised of the regulation and its implementation via this publication. In addition, the Board is preparing a poster arising out of this accident that will be sent to employers in the logging industry.
3. As a change in the Occupational Health and Safety regulation would be required to implement recommendation #3, this recommendation will be referred to the Policy and Regulation Development Bureau for consideration in the ongoing regulation review process.
4. A whistle has been a required part of faller personal protective equipment for many years. This recommendation will also be forwarded to the Policy and Regulation Development Bureau for consideration.
5. As a change in the Occupational Health and Safety Regulation would be required to implement recommendation #5, it is also being forwarded to the Policy and Regulation Development Bureau for consideration.
6. Same as above.
7. This recommendation is largely covered by the existing provisions of Part 33 of the Occupational Health and Safety Regulation dealing with occupational first aid requirements. This section states that before operations begin at a workplace, the employer must develop written procedures for transporting injured workers. The written

procedures must include who and how to call for transportation and prearranged routes in and out of the workplace. For certain operations, the employer is required to have an emergency transportation vehicle or industrial ambulance on site.

Council of Forest Industries

1. It is the custom of the Council to circulate the Reports of Inquiry to their members for information and opportunity to comment.

MacMillan Bloedel Limited

1. In difficult engineering areas, Stillwater Division now brings in an experienced faller/bucker to field review the falling boundary for any potential hazards prior to falling of the setting. An engineer accompanies the faller/bucker during his field review to lead him around the setting.
2. Currently, Stillwater Division and the local Ministry of Forests representatives have monthly pinch-point meetings to identify settings that are either behind in the approval process or have been rescheduled for logging and need to be fast tracked.

Alliford Bay Logging Ltd.

1. The company policy for hiring fallers/buckers is to ensure a minimum of 5 years experience and reference checks of potential applicants.
2. As a contractor, Alliford Bay Logging is not usually involved in the approval process.

Inquest No. 13 (Correctional Facility)

On June 12, 1998, an inquest was held at Mission, B.C. into the death of a 48-year-old male who died on January 9, 1998 at Mission Memorial Hospital.

The subject was serving a federal sentence at Mission Medium Security Institution. He was known to have a history of illicit drug use. The subject was being treated at Health Services within the institution when he collapsed and was transferred to hospital.

The jury found that death resulted from exsanguination as a result of blood loss from an aortic aneurysm and classified the death as natural.

The recommendations of the jury, forwarded to Correctional Services of Canada, were as follows:

1. When a nurse reports an inmate's medical condition to the doctor, the doctor must examine the inmate physically within twelve hours or sooner.
2. Logbook medical communication needs to be specific and highlighted in order for guards to be aware of the medical condition of inmates.
3. Higher level of first aid training for prison staff.

Responses:

Correctional Services Canada

1. The current practice is that nursing staff at all facilities are trained in physical assessment. When a medical condition is viewed as being serious, health care staff may either contact the contract physician or call 911 and have the inmate removed to a community hospital. The contract physicians attend their facilities once or twice a week. Access to emergency services is provided on a 24-hour basis.
2. Medical concerns are always shared with operational staff, where there is a need to do so. The medical concerns are noted in the supervisor's logbook and shared with all staff

through shift briefings, general staff briefings and daily managerial meetings.

3. As a result of consultations between Health Care, Security and Personnel and Training, it was concluded that a higher level of first aid training would not have assisted in detecting nor diagnosing something technical, such as an intra-abdominal hemorrhage.

Inquest No. 14 *(Correctional Facility)*

On June 15, 1998, an inquest was held at Prince George, B.C. into the death of a 39-year-old male who died on October 26, 1996 in his cell at Prince George Regional Correctional Centre (PGRCC).

The subject was diagnosed with schizophrenia and was taking Clozapine and psychiatric treatment at the centre.

The jury found that death resulted from a hypersensitivity to Clozapine, resulting in myocarditis, with associated hypersensitivity hepatitis.

The recommendations of the jury, which were forwarded to the Corrections Branch, were as follows:

1. Correction officers to adhere to formal check procedures.
2. Clozapine clinic to be made aware of possible side effects of hypersensitivity myocarditis.
3. Psychiatrists to work closely with other medical practitioners to ensure physical well being of the patient.

Responses:

Corrections Branch

1. Policy has been reaffirmed and staff was reminded of the need for diligence in the performance of their duties.
2. The attending physician has been asked to contact the Clozapine Clinic to make them aware of this case.
3. Discussions have been held with the contracted physician at Prince George Regional Correctional Centre and Forensic Services to ensure a strong working relationship. Forensic will be adding a full time nurse to PGRCC's complement to help inmates with mental health issues.

Inquest No. 15 *(Correctional Facility)*

On June 17, 1998, an inquest was held at Prince George, B.C. into the death of a 40-year-old male who died on September 29, 1996 at Prince George Regional Correctional Centre. The subject was found hanging in his cell

The jury found that death resulted from hanging and classified the death as a suicide.

The recommendations of the jury, which were forwarded to the Corrections Branch, were as follows:

Corrections Branch

1. If possible, motion detector lighting might be advisable so guards would be alerted when inmates are mobile at night.
2. The colour of bedding should be changed so it would not be the same color as the walls.

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3. Where possible, past medical and mental health information should be gathered by medical staff.

Responses:

Corrections Branch

1. Changes in lighting, vents have been addressed. Grates have been adjusted.
2. Motion detector lighting was not viewed as achievable in an operational setting since inmates often move at night.
3. Evidence was given that the sheet used in this case was different than the walls. It is believed that the lighting was the underlying concern and this has been addressed.
4. Obtaining past medical and mental health information may not be feasible as it would require obtaining the written permission of each inmate to get their medical information from a variety of physicians, local hospitals, and health clinics.

Inquest No. 16 (Correctional Facility)

On June 19, 1998, an inquest was held at Prince George, B.C. into the death of a 58-year-old male who died on August 20, 1996 at Prince George Regional Hospital. The subject was remanded to the Prince George Regional Correctional Centre, and diagnosed with metastatic carcinoma while in custody.

The jury found that death resulted from metastatic esophageal cancer and classified the death as natural.

The jury made no recommendations.

Inquest No. 17 (Police Cell)

On September 15, 1998, an inquest was held at Burnaby, B.C. into the death of a 39-year-old female who died on December 5, 1997 in a Vancouver Police Department cell. The subject was arrested on an outstanding warrant and placed in Vancouver Police cells. A note on the subject's file indicated that she was taking prescription medications and had numerous medical problems. There was no indication of suicide risk.

The jury found that death resulted from hanging, exacerbated by multi-drug toxicity and classified the death as suicide.

The recommendations of the jury, which were forwarded to the Corrections Branch and the Vancouver Police Department, were as follows:

Corrections Branch

1. All inmates in holding cells be checked at least every 15 minutes. To ensure that these checks are carried out, the new facility at 222 Main have a system of proximity sensors on each jail cell to automatically record all checks of inmates.
2. Leggings and bras be added to the list of items confiscated on admission to the holding cells at 312 Main.
3. Audio be added to the video cameras in 222 Main, and the tapes be kept for a minimum of 14 days.

Vancouver Police Department

1. The department ensure the "Jail 8" form is always completed by the arresting officer and any unusual activity such as ingestion of drugs be noted.

The Coroner further recommended to Vancouver Police Department

1. The Vancouver Police Department should consider instituting a policy that members not permit persons under arrest to consume any medications until they are admitted to holding cells. Any known or suspected consumption of medication should be reported to jail intake staff.

B.C. Medical Association, The College of Physicians and Surgeons of B.C., the Ministry of Health

1. The above agencies co-operate to establish a protocol for the sharing of patient information between hospitals and physicians. Physicians should be informed of acute or chronic life-threatening behaviours resulting in hospitalization of their patients.
2. Education programs be made more available for currently licensed physicians to better detect and treat patients with chronic pain and/or polysubstance abuse.

Responses:

Ministry of Attorney General, Corrections Branch

1. Vancouver Jail policy on checks of all pre-mand and high-risk prisoners will be at least every fifteen minutes, which is consistent with current Corrections Branch policy. Proximity sensors have not been investigated for correctional sites because of the cost.

The Vancouver Jail Policy and Procedures Manual has been revised to include leggings/pantyhose as items of clothing removed from prisoners, as either could be used as a ligature.

2. After lengthy discussion, it was decided that bras would not be removed from females unless a person was evaluated as being at risk. The Vancouver Jail cells are designed to ensure there is no place to tie a ligature. In

addition, five intake cells are monitored by closed circuit TV, as are the two special handling cells for females.

3. Facilities Management is reviewing the addition of audio to existing video cameras in the booking area only. Audio is not being considered in the intake or special handling cells. The audio would have to be very sophisticated to enable a correctional officer to monitor five to seven calls and determine where the sound originated. All tapes (booking desk) are kept for twelve months.

Vancouver Police Department

1. In reference to ensuring the "Jail 8" form is completed, Section 128 of the Regulations and Procedures Manual (RPM) requires that the arresting member provide a completed Arrest Report and include whether the prisoner is a known drug addict, has taken any drugs, or if they require or are presently on any medication.
2. While the RPM does not specifically address the issue of prisoners ingesting medication, Section 77.2 states that members are personally responsible for searching their prisoners and for their safe custody at all times. While this section does not speak directly to the ingestion of medication by prisoners, the responsibility of members for their prisoner's safe custody includes the monitoring of the ingestion of medication. Section 128 of the RPM requires that the arresting member must note on the Arrest Report form whether the prisoner requires or is presently on medication. The current policies adequately address these recommendations.

British Columbia Medical Association

1. A protocol for sharing patient information between hospitals and physicians would be difficult to implement as each individual health region is responsible for its own

information system. Each institution also appears to have its own information system requirements. There is, however, an attempt being made by a number of regions to improve their information systems and eventually it is hoped that this will allow access and communication between institutions and physicians' offices.

2. Education programs to better detect and treat patients with chronic pain and substance abuse problems are currently taught in medical schools. In addition, there are a number of courses available on an annual basis regarding chronic pain and substance abuse.

College of Physicians & Surgeons of British Columbia

1. The College does have in place educational programs on the management of chronic pain and the appropriate use of narcotics. In addition, the College funds and co-sponsors workshops and seminars on the treatment of addiction. The College has also been primarily responsible for the introduction of the PharmaNet database into emergency departments around the province in order that a patient's recent drug profile might be reviewed.

Ministry of Health

1. The College of Physicians is conducting, with ministry support, a pilot project allowing PharmaNet access to physicians in private offices. This allows physicians to understand drug regimes of individuals they are treating.
2. With respect to educational programs, the College of Physicians offers courses dealing with chronic pain/substance abuse.

A number of responses were also received from various health regions, addressing the above issues.

Inquest No. 18 (Correctional Facility)

On September 24, 1998, an inquest was held at Abbotsford, B.C. into the death of a 48-year-old male who died on January 5, 1998 at Matsqui Institution in Abbotsford.

The jury found that the cause of death was pneumonia resulting from HIV and classified the death as natural.

The jury made no recommendations.

Inquest No. 19 (Medical)

On September 28, 1998, an inquest was held at Burnaby, B.C. into the death of a 24-year-old male who died on April 6, 1995 at Vancouver Hospital.

The subject had a corrected congenital heart defect and subsequent pacemaker insertion. In early 1995, the subject began to experience non-life threatening cardiac arrhythmia. He was treated by cardiologist with one medication which did not convert heart rhythm. The subject was given new medication and collapsed at home, 50 minutes after taking initial dose. The drug provided to the subject had been taken off the market in the United States in 1992. No new patients were to be given this medication after this time. Numerous questions have arisen as to the availability and control of this drug.

The jury found that the cause of death was heart failure as a result of multifactorial events; namely congenital/structural heart disease; and possibly a combination or addition of medications, or pulmonary embolus. The jury classified the death as undetermined.

The recommendations of the jury, forwarded to the Head of Cardiology - Faculty of Medicine - University of British Columbia, College of Physicians and Surgeons of British Columbia, the B.C. Ministry of Health, Health and Welfare

Canada, Chief of Cardiology - B.C. Hospitals, B.C. Cardiac Society, Bristol-Myers Squibb, Pharmaceutical Manufacturers, Pacemaker Clinic, and Vancouver Hospital, were as follows:

Head of Cardiology - Faculty of Medicine - U.B.C. College of Physicians and Surgeons of B.C.

1. Review this case for information, education, and action as deemed appropriate.

College of Physicians and Surgeons of B.C.
Royal College of Physicians and Surgeons
Ministry of Health

1. Review the eligibility criteria of practitioners with sub-specialties that are lacking in various areas of medicine in the country so that Canadian facilities and patients are not compromised by lack of appropriately trained physicians.
2. Recommend a committee be struck to determine other academic institutions outside Canada and the United States which would be acceptable to receive accreditation from the College of Physicians and Surgeons of British Columbia and the Royal College of Physicians and Surgeons.

Ministry of Health
Health and Welfare Canada

1. Recommend a committee be struck to determine funding possibilities for the training of cardiologists with a sub-specialty in adults with congenital heart disease.

College of Physicians and Surgeons of B.C.

1. Notify all physicians in B.C. of the continuing necessity to obtain informed consent for all treatments.
2. Notify family physicians, emergency physicians and cardiologists of the existence

and function of the Pacific Adult Congenital Heart Clinic.

Health and Welfare Canada
Health Protection Branch

1. Criteria for the facilitation of drug movement between the manufacturer and physicians be reviewed with a view of acknowledging the existing practice of allowing physicians the professional freedom to prescribe for immediately life-threatening emergencies, compassionate and chronic conditions.
2. That when drugs are released via the Special Access Program, other than in clinical trials, that conditions pertaining to the Letter of Authorization be strictly adhered to by the practitioner and, in particular, the reporting of information respecting the use of the drug for a specific patient, and adverse events and accounting for all quantities of the drug.
3. The Special Access Program, as per section C.08.010 of the Food and Drug Act regulations, request an accounting of the doctor involved for all quantities of the drug encaïnide.
4. All penalties under the Food and Drug Act and specific to the Special Access Program be enforced.
5. Drugs requested through the Special Access Program be dispensed through a licensed pharmacy.
6. The requirement of reporting an adverse drug reaction be changed to require the reporting of any significant adverse event.
7. A mechanism be developed whereby the Special Access Program ensure that up-to-date information is relayed to physicians who have acquired Special Access medications.

Ministry of Health
Chief of Cardiology, B.C. Hospitals
Dept. Of Cardiology, Faculty of Medicine, UBC
B.C. Cardiac Society

1. A teaching synopsis of this case be created and distributed for use in all medical teaching facilities and hospitals in B.C.
2. That discussion occur and a plan be developed to retrieve all pacemakers following the death of implanted persons so that functional testing may occur if required.

Bristol-Myers Squibb
Health and Welfare Canada
Health Protection Branch

1. That a registry of physician recipient(s) of Special Access Drugs be kept by drug so that if special directions in the use of the drug arise all the physicians can be notified.
2. That all drugs supplied through the Special Access Program be individually marked with dosage and drug name clearly identified.

Health and Welfare Canada, Health Protection Branch
Pharmaceutical Manufacturers

1. Once permission to use a drug is obtained by a practitioner under the Special Access Program, the practitioner shall acknowledge to the manufacturer and the Special Access Program, in writing, that they have read and understand the product information bulletin specific to that drug.

Pacemaker Clinic

1. Upon identification of any unusual readings of an ECG or telephonic transmission strip, the appropriate physician shall be notified as soon as possible and a record of such notification shall be kept.

2. Copies of any unusual readings shall be sent to the appropriate physician and to hospital records.

3. The clinic advises all B.C. cardiologists of their current hours of operation and the function of the clinic so that this information can be passed to patients.

Ministry of Health
Vancouver Hospital

1. The plan to have every patient record available via computer within the hospital complex should be implemented as quickly as possible.

Responses:

The responses to the recommendations have not been summarized here due to their length.

Inquest No. 20 (Police Custody)

On September 30, 1998, an inquest was held at Terrace, B.C. into the death of a 76-year-old female who died on March 26, 1998 at Mills Memorial Hospital.

The RCMP, based on information that marijuana was being cultivated, were in the process of executing a search warrant at a residence. The subject, who was at the residence, indicated that she wished to lie down to rest. She was noted to have stopped breathing shortly thereafter.

The jury found that death resulted from subarachnoid hemorrhage, as a result of severe atherosclerosis and classified the death as natural.

The recommendations of the jury reinforced the need for police officers to maintain CPR and first aid certification.

Inquest No. 21 (Industrial)

On October 5, 1998, an inquest was held at Nanaimo, B.C. into the death of a 66-year-old man who died on December 2nd in the ocean waters off Gabriola Island, B.C.

The subject was a deckhand on a fishing vessel which capsized while engaged in a herring fishing operation in Pylades Channel. The herring was being harvested as baitfish for sports fisherman, home canning etc. The fishery was sanctioned and monitored by the Department of Fisheries and Oceans, a federal agency.

The jury found that death resulted from hypothermia as a result of the capsizing of a fishing vessel.

The recommendations of the jury, which were forwarded to Transport Canada - Marine Safety, were as follows:

1. That Emergency Position Indicating Radio Beacon (EPIRB) be phased in with the Geographical Positioning Signal (GPS).
2. Provisions in the form used by Transport Canada Marine Safety Inspectors to perform the quadrennial inspections should include the obtaining and recording of any major modifications and additional weight to a fishing vessel that adversely affect the stability characteristics of the vessel. Entry (if any) in this particular area should be forwarded to proper authorities.

The Coroner further recommended

1. That consistent application of stability criteria be immediately instituted and updated to reflect current practices in the fishing industry.

Responses:

No response to date.

Inquest No. 22 (Police Custody)

On October 13, 1998, an inquest was held at Chilliwack, B.C. into the death of a 67-year-old male who died on February 24, 1998 at St. Paul's Hospital in Vancouver.

The subject had been found disoriented and agitated, near his residence in Chilliwack. There was smell of liquor present. The subject refused to stay at his residence, and so was taken into custody by Chilliwack RCMP. The subject's condition deteriorated and he was transported to hospital.

The jury found that death resulted from multi-organ failure as a result of peripheral vascular disease and classified the death as natural.

The jury had no recommendations.

Inquest No. 23 (Police Cell)

On October 20, 1998, an inquest was held at Fort St. John, B.C. into the death of a 41-year-old female who died on May 7, 1998 at Fort St. John Hospital.

The subject was reported to be intoxicated in public, was picked up by police and transported to the police station. The subject lost consciousness in the booking room and was transported to hospital, where she was pronounced dead.

The jury found that the cause of death was streptococcus pneumonia and classified the death as natural.

The recommendations of the jury, which were forwarded to the Ministry of Children & Families, Health Canada (National Native Alcohol & Drug Abuse Programs), RCMP "E" Division, and the Pioneer Inn, were as follows:

Ministry for Children & Families

1. That a detoxification centre be funded and situated in Fort St. John to serve the area and the people.

RCMP, "E" Division

1. That formal training be provided to all members (police) in distinguishing intoxication versus medical problems, in assessing level of consciousness prior to admittance to cell.

The Pioneer Inn

1. That written procedures be in place for humane treatment of any and all intoxicated persons.

Health Canada (National Native Alcohol & Drug Abuse Programs)

1. Funding for First Nation's communities to develop awareness of alcohol abuse and to educate all members of the public and children on the results of alcohol abuse.

Responses:

Health Canada

1. The Department already significantly funds the prevention and treatment of alcohol, drug and solvent abuse in the Fort St. John area. Setting priorities for the delivery of programs is the joint responsibility of the Bands and the board of the treatment program.

RCMP, "E" Division

1. The training branch is developing a national medical training program that would address level of consciousness assessment, along with other medical issues. It is anticipated that this program would be available for implementation in the year 2000.

Inquest No. 24 *(Correctional Facility)*

On October 30, 1998, an inquest was held at Kamloops, B.C. into the death of a 26-year-old male who died on November 30, 1997 at Royal Inland Hospital at Kamloops, B.C.

The subject was on remand at Kamloops Regional Correctional Centre. He requested medical attention and was taken to hospital by ambulance. The subject's condition was diagnosed as neurological and a CAT scan revealed a large subarachnoid hemorrhage. His condition quickly deteriorated.

The jury found that the cause of death was cerebral hemorrhage and classified the death as natural.

The jury made no recommendations.

Inquest No. 25 *(Police Custody)*

On November 9, 1998, an inquest was held at Burnaby, B.C. into the death of a 62-year-old male who died in Vancouver on May 28, 1998 while being transported in a prisoner pickup wagon.

The subject was picked up by Vancouver City Police after he was found lying on a curb, apparently impaired. He was later found to be unconscious and not breathing in the police wagon.

The jury found that the cause of death was probable positional asphyxia, complicated by pre-existing pneumonia and acute and chronic alcohol abuse.

The recommendations of the jury, which were forwarded to the Vancouver Police Department, were as follows:

1. Direct routing from pick-up to delivery of persons being transported via police wagon.

2. Existing capabilities of the intercom system be used at all times when transporting persons.
3. Careful consideration be taken when placing a person in a wagon.

No response to date.

Inquest No. 26 (Police Cell)

On November 16, 1998, an inquest was held at Burnaby, B.C. into the death of a 37-year-old male who died on July 29, 1997 in a Surrey RCMP cell.

Emergency Health Services (EHS) responded to a residence in Surrey. Upon their arrival, the subject appeared to be intoxicated and incoherent. He was taken to hospital, treated for acute alcohol withdrawal and discharged. EHS were called again to the subject's home for a possible stroke. He was taken to hospital, became increasingly more agitated and had to be restrained. RCMP were called to remove the subject to cells. Due to the subject's agitated state, he was hog-tied and taken by police cruiser and placed in a drunk tank. The subject was later found deceased in his cell.

The jury found that the cause death was unknown, as a result of several factors including alcohol intoxication, excited delirium and hyper-exertion. The jury classified the death as undetermined.

The recommendations of the jury, forwarded to the Mayor of Surrey, the Attorney General, RCMP "E" Division and OIC Surrey Detachment, were as follows:

The Mayor of the City of Surrey

1. A detox centre be constructed and that cell surveillance cameras be of better quality.

Attorney General, RCMP "E" Division

1. That the RCMP should have two officers in a vehicle when transporting prisoners in hog-tied positions.
2. Law enforcement personnel should study alternate means of restraint rather than hog tying.

Responses:

Office of the Mayor

1. While the City is considering its evaluation of the establishment of a detoxification centre, the jury's recommendation has been forwarded to the Fraser Valley Regional Health Centre for their consideration. The issue of surveillance cameras is being reviewed by the RCMP.

Attorney General

1. Confirm that RCMP "E" Division and the Officer in Charge of Surrey Detachment are the appropriate offices to address changes to police operational procedures.

RCMP "E" Division

1. The RCMP is presently reviewing existing policies to ensure public safety concerns are being addressed. A formal response to the jury's recommendations will be provided once civil litigation in regard to this death is resolved.

Inquest No. 27 (Industrial)

On November 16, 1998, an inquest was held at Campbell River, B.C. into the death of a 33-year-old male who died on January 16, 1998 at an industrial mining site near Campbell River, B.C.

The subject was one of two miners fatally injured when they were trapped by a massive rock fall in an underground mine.

The jury found that the cause of death was asphyxia as a result of compression of the face and chest, associated with crush injuries in a mining accident.

The recommendations of the jury, which were forwarded to the Ministry of Energy and Mines and the Quinsam Coal Corporation, were as follows:

Ministry of Energy and Mines

1. That when determining a mining plan, due consideration be given to all aspects of safety using the safest method of mining.
2. A "black tag" system be initiated similar to other jurisdictions. This would include all aspects of training and certification.
3. The Ministry seeks additional funding to support more frequent mine inspections.

Quinsam Coal Corporation

1. That there be additional resources for ongoing theoretical and practical training.
2. Eight foot roof bolts be used at all intersections
3. At least one member of the Occupational Health and Safety Committee (OHSC) be on each work shift. This member be clearly identified to all crewmembers at each shift change.
4. Whenever practical, crews should be kept together as a working unit for the development and depillaring process.
5. That all rehabilitation work be done in a timely manner.

6. That a position of full-time safety examiner be established. This position could be staffed by one or more persons at the discretion of the OHSC.
7. There be ongoing safety training provided to all workers to enable them to identify safety problems within the work environment.
8. All known faults and slips be clearly marked to make them more apparent to all personnel.

Responses:

Ministry of Energy and Mines

1. In approving mine plans, the Mining Branch will continue to give full consideration to the plan to ensure it complies with the requirements of the Mines Act and Health Safety and Reclamation Code for Mines in British Columbia. The Branch will continue its policy of only approving those plans that are technically and environmentally sound and represent safe mining practice.
2. The Mines Branch is working with the company to develop an appropriate system with respect to training and disposition of mine personnel.
3. The budget put forward for consideration for the 1999/2000 fiscal year contains sufficient funding to allow the Branch to fulfill its mandate.

Quinsam Coal Corporation

1. The recommendations are being considered and implemented where possible. It is recognized that the shift boss has sufficient responsibilities respecting examination of the mine to ensure safety and compliance and, as such, it will ensure that this position has sufficient capacity to carry out duties as intended by the Health, Safety and Reclamation Code for Mines in British Columbia.

Inquest No. 28 (Police Shooting)

On November 24, 1998, an inquest was held at Burnaby, B.C. into the death of a 67-year-old male who died on December 2, 1997 at Vancouver, B.C.

The subject was shot by Vancouver police after he approached an officer with a knife. Verbal commands and the use of pepper spray and a baton all failed to stop the suspect from approaching the officer. The subject had a lengthy psychiatric history.

The jury found that the cause of death was internal bleeding as a result of a gunshot wound to the abdomen and classified the death as a suicide.

The recommendations of the jury, which were forwarded to the Ministry of Health (for information only) and the Vancouver City Police, were as follows:

Ministry of Health

1. That increased sharing of information regarding patient history could be helpful in avoiding similar situations.

Vancouver City Police

1. Situations such as this death could be avoided if the police department had more non-lethal force options available to them.

No response to date.

Inquest No. 29 (Other)

On November 30, 1998, an inquest was held at Victoria B.C. into the death of a 47-year-old female who died in her residence at Victoria, B.C.

The jury found that the cause of death was a puncture wound to the abdominal wall resulting in massive internal bleeding and classified the death as a suicide. Evidence revealed that the subject had placed three successive calls to 911 on the evening prior to her death.

The recommendations of the jury, which were forwarded to the Victoria Police Department, were as follows:

1. In instances where an operator receives a call from a person who is threatened with bodily harm, an attempt, manpower allowing, should be made to send an officer to the scene to begin an assessment of the situation. If sufficient manpower is not available, send someone to the scene at first available opportunity.
2. That 911 operator go through a series of formal training, such as multi-cultural sensitivity training and role playing with mock situations, on a semi-annual basis.
3. In cases where the 911 operator is unsure as to the urgency of the call, the supervising officer be asked to "listen" to the call.

Response:

The Victoria Police Department responded as follows:

1. The Victoria Police Department Communications Centre Policy relating to threats has now been amended to read: "If the threats are in progress, or are threats to commit serious bodily harm or murder, the call shall be routed to the dispatcher who is responsible for sending units to the scene to assess the situation. Upon completion of the call, an incident number will be assigned."
2. 1999 funding for four annual training days has been approved for communications specialists. A variety of training issues will

be addressed during these training days, including multi-cultural sensitivity training.

3. Although there has always been the practice of Communications Section personnel to consult with a supervisor whenever they are unaware of how to appropriately respond to a situation, this procedure has now been entrenched within the Communications Centre Rules.

Inquest No. 30 *(Correctional Facility)*

On December 8, 1998, an inquest was held at Abbotsford, B.C. into the death of a 61-year-old male who died on May 13, 1998 at Matsqui Institution.

The jury found that the death resulted from lung cancer and classified the death as natural.

The jury made no recommendations.

